MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3585

CERTIFICATE OF DEATH

03578

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Washington

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 4 years
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Jackson Nursing Home
d. STREET ADDRESS: 322 N. Potomac St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Maggie Middle Lavinia Last Albert
4. DATE OF DEATH: Month March Day 23 Year 1959

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Feb. 12, 1883
9. AGE (In years last birthday): 76 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Carroll County Md.
12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: John Eisenhart
14. MOTHER'S MAIDEN NAME: Mary Wilt

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 216-07-3098
17. INFORMANT: Mrs. Marguerite Moore Address: Hag. Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Congestive Heart Failure — INTERVAL BETWEEN ONSET AND DEATH: 6 wks.
DUE TO
(b): Metastatic Cancer — 6 mos.
DUE TO
(c): (Origin unknown.)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

199.2

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 3.16.59, 19____, to 3.23.59, 19____, that I last saw the deceased alive on 3-26-59, 19____, and that death occurred at 5.45 P.M., from the causes and on the date stated above.

3.23.59
ACTUAL SIGNATURE: S. Earl Young M.D.
ADDRESS (Street, city or town, state): 148 N. Potomac St.
DATE SIGNED: 3/24/59

PHYSICIAN'S NAME (Type): S. Earl Young
Hagerstown Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 3-26-59
22c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery
22d. LOCATION (City, town, or county) (State): Hagerstown Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Scott F. Minnich & Son
ADDRESS: Hagerstown Md.
24a. REGISTRAR: DATE MAR 30 59
24b. REGISTRAR'S SIGNATURE: Arthur L. Young

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3586 CERTIFICATE OF DEATH

Reg. Dist. No. 03579

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 5 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Wash. Co. Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md. b. COUNTY: Wash.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 03 Hagerstown
d. STREET ADDRESS: 401 Brown Ave.,
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Elva; Middle: May; Last: Alter

4. DATE OF DEATH: Month: 3; Day: 2; Year: 19 59

5. SEX: female

6. COLOR OR RACE: white

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Oct. 29, 1893

9. AGE (In years last birthday): 65 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife

10b. KIND OF BUSINESS OR INDUSTRY: home

11. BIRTHPLACE (State or foreign country): State Line, Pa.

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: James Vernon Bower

14. MOTHER'S MAIDEN NAME: Maggie Walk

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no

16. SOCIAL SECURITY NO.: none

17. INFORMANT — Address: Ira D. Alter — Hagerstown, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Uremia — INTERVAL BETWEEN ONSET AND DEATH: 3 wks
DUE TO (b): Carcinoma of ovary with generalized metastases — 26 mos.
DUE TO (c):
175.0
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour, a. m. / p. m., Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 6 Aug., 1958, to 2 March 1959, that I last saw the deceased alive on 2 March, 1959, and that death occurred at 5:00 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Harold H Gist M.D.
ADDRESS (Street, city or town, state): HAROLD H. GIST, M. D. 111 North Potomac St. Hagerstown, Maryland
DATE SIGNED:
PHYSICIAN'S NAME (Type):

22a. BURIAL, CREMATION, REMOVAL (Specify): burial
22b. DATE THEREOF: 3-5-59
22c. NAME OF CEMETERY OR CREMATORY: Rose Hill
22d. LOCATION (City, town, or county) (State): Hagerstown Md.

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Fred W. Kraiss — Hagerstown, Md.

24a. REC'D BY REGISTRAR — DATE: MAR 5 '59

24b. REGISTRAR'S SIGNATURE: Arthur L. Kraiss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

3657 — Reg. Dist. No. 03586

1. PLACE OF DEATH
a. COUNTY: WASHINGTON — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CLEAR SPRING
c. LENGTH OF STAY IN 1b: LIFE
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: MAIN STREET

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MD. — b. COUNTY: WASHINGTON
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X CLEAR SPRING
d. STREET ADDRESS: 1 MAIN STREET
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First HOWARD — Middle EDWIN — Last ANKENEY

4. DATE OF DEATH: Month 3 — Day 20 — Year 19 59

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 8/12/03

9. AGE (In years last birthday): 55 yrs.

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): STORE KEEPER

10b. KIND OF BUSINESS OR INDUSTRY: LIQUOR

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: HOWARD I. ANKENEY

14. MOTHER'S MAIDEN NAME: ELLA DAVIS

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT: MRS. ANNA ANKENEY — Address: CLEAR SPRING, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a): Acute Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: Sudden

DUE TO (b): Hypertensive Cardiac Dis. — 2 yrs.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 420.1

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Nov. 15, 19 58 to Mar 20, 19 59, that I last saw the deceased alive on Mar 15, 19 59, and that death occurred at 7.9 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: David R Brewer M.D. — ADDRESS (Street, city or town, state): Clear Spring Md. — DATE SIGNED: 3/21/59

PHYSICIAN'S NAME (Type): David R. Brewer

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: 3/23/59

22c. NAME OF CEMETERY OR CREMATORY: ST. PAULS CEMETERY

22d. LOCATION (City, town, or county) (State): CLEAR SPRING, MD.

23. FUNERAL DIRECTOR'S SIGNATURE: John F. Clark — ADDRESS: CLEAR SPRING, MD.

24a. REC'D BY REGISTRAR DATE: MAR 24 59

24b. REGISTRAR'S SIGNATURE: Arthur L. Kreitz

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospitol or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3587 **CERTIFICATE OF DEATH**

03581

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 48 years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 232 E. Washington St.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 03 Hagerstown
d. STREET ADDRESS: 232 E. Washington
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Vernon; Middle Marshall; Last Bachtell

4. DATE OF DEATH: Month March; Day 7; Year 19 59

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: August 16, 1891

9. AGE (In years last birthday): 67 yrs.
IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Collector

10b. KIND OF BUSINESS OR INDUSTRY: City of Hag.

11. BIRTHPLACE (State or foreign country): Smithsburg Md.

12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: Ellis Uperdegrove

14. MOTHER'S MAIDEN NAME: Grace Bachtell

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): ---
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 214-09-5551

17. INFORMANT: Mrs. Cottie Miller Address: Hagerstown Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arteriosclerotic Heart Disease with Myocardial failure — INTERVAL BETWEEN ONSET AND DEATH: 10 yrs
DUE TO
(b)
DUE TO
(c)

420.0

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Feb, 1946, to Mar 7, 1959, that I last saw the deceased alive on Mar 5, 1959, and that death occurred at 6 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: F F Lusby, M.D.
ADDRESS (Street, city or town, state): 230 N. Potomac St. Hagerstown Md.
DATE SIGNED
PHYSICIAN'S NAME (Type): Frank F. Lusby

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 3-9-59
22c. NAME OF CEMETERY OR CREMATORY: Smithsburg Cemetery
22d. LOCATION (City, town, or county) (State): Smithsburg Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Scott F. Minnich & Son
ADDRESS: Hagerstown Md.
24a. REG'D BY REGISTRAR DATE: MAR 9 '59
24b. REGISTRAR'S SIGNATURE: Arthur L. Hand / Arthur L. Hand

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3658 Item 8 Film C240 4-2-59 et

CERTIFICATE OF DEATH

03582

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington ~~Frederick~~ MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hancock Md
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Hancock Rest Home

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland Md 0102-2
d. STREET ADDRESS 304 Washington St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) First Isaac Middle Henry Last Bane
4. DATE OF DEATH Month 3 Day 23 Year 59 19
5. SEX Male
6. COLOR OR RACE W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH 1/18/1866 / 6/27/1
9. AGE (In years last birthday) 92 yrs.
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bank Store
10b. KIND OF BUSINESS OR INDUSTRY Grocery
11. BIRTHPLACE (State or foreign country) Headsville (W Va
12. CITIZEN OF WHAT COUNTRY? U S A
13. FATHER'S NAME Geo W Bane
14. MOTHER'S MAIDEN NAME Sarah Head Headsville
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. None
17. INFORMANT Address Miss Nellie Bane 304 Wash St. Cumb Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prostatic Hypertrophy
610 X
DUE TO (b) Anuria
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 3/22/59 19____, to 3/23/59 19____, that I last saw the deceased alive on ____ 19____, and that death occurred at 8:30 a.m. p.m. from the causes and on the date stated above.

ACTUAL SIGNATURE H.E. Table M.D. ADDRESS (Street, city or town, state) Hancock Md DATE SIGNED

PHYSICIAN'S NAME (Type) H E Table M D

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 3/25/59
22c. NAME OF CEMETERY OR CREMATORY Rose Hill Mausoleum
22d. LOCATION (City, town, or county) Cumberland (State) Md

23. FUNERAL DIRECTOR'S SIGNATURE Lewis Stein Inc ADDRESS Cumb Md
24a. REC'D BY REGISTRAR DATE MAR 26 '59
24b. REGISTRAR'S SIGNATURE Arthur S. Hawk

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3659

CERTIFICATE OF DEATH

Reg. Dist. No. 03583

1. PLACE OF DEATH
a. COUNTY Washington MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown
c. LENGTH OF STAY IN 1b 5 Months
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Gateway Convelesent Home

2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)
a. STATE Maryland b. COUNTY Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown
d. STREET ADDRESS 1704 West Washington Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First John Middle Wesley Last Barnes

4. DATE OF DEATH Month March Day 9 Year 1959

5. SEX Male
6. COLOR OR RACE White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH August 18, 1865
9. AGE (In years last birthday) 93 yrs
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer
10b. KIND OF BUSINESS OR INDUSTRY Retired
11. BIRTHPLACE (State or foreign country) Maugansville Wash. Co. Md.
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME Thornton Barnes
14. MOTHER'S MAIDEN NAME Mary Ripple

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No (If yes, give war or dates of service) -------
16. SOCIAL SECURITY NO. 218-34-1857
17. INFORMANT Raymond W. Barnes Address 1309 Virginia Ave Hagerstown Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arterio Sclerotic Heart Dis — INTERVAL BETWEEN ONSET AND DEATH 2 yrs.
420.0
DUE TO (b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o m. p m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that I attended the deceased from Nov 15, 1958, to Mar 9, 1959, that I last saw the deceased alive on Mar 9, 1959, and that death occurred at 8:30 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE David R Brewer M.D. ADDRESS (Street, city or town, state) Box 206 DATE SIGNED 3/10/59

PHYSICIAN'S NAME (Type) David R. Brewer Clear Spring Md.

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 3-12-59
22c. NAME OF CEMETERY OR CREMATORY Manor Cemetery
22d. LOCATION (City, town, or county) (State) Tilghmington Wash. Co. Md.

23. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman ADDRESS 40 E. Antietam St. Hagerstown Md.
24a. REC'D BY REGISTRAR DATE MAR 13 '59
24b. REGISTRAR'S SIGNATURE Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed and filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3588 . **CERTIFICATE OF DEATH**

Reg. Dist. No. 03584

1. PLACE OF DEATH
a. COUNTY Washington MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Wash. Co. Hospital

2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission)
a. STATE Pa.
b. COUNTY Franklin
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) STATE LINE
d. STREET ADDRESS STATE LINE, PA
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First MARY Middle BLANCHE Last BARNHART

4. DATE OF DEATH Month MARCH Day 1 Year 1959

5. SEX F
6. COLOR OR RACE W
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH Oct. 15, 1905
9. AGE (In years last birthday) 53 yrs
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY Home
11. BIRTHPLACE (State or foreign country) Franklin Co., Pa.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Charles E. Casey
14. MOTHER'S MAIDEN NAME Eliza Elliott

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Address Walter Barnhart - State Line, Pa.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Postoperative Pulmonary Embolus — INTERVAL BETWEEN ONSET AND DEATH: 30 sec.

175.0

DUE TO (b) Postoperative Phlebothrombosis — 8 days

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last — DUE TO (c) Abdominal Carcinomatosis - Primary Site: Ovary — Approx. 2 months

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Coronary Spasticity.- Post Infarction Myocardial Fibrosis

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 9-1-39, 19____, to 3-1-59, 19____, that I last saw the deceased alive on 2-28-59, 19____, and that death occurred at 1:45 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE W. C. Brewer M.D. ADDRESS (Street, city or town, state) 359 E. Baltimore St., Greencastle, Pa. DATE SIGNED 3-1-59

PHYSICIAN'S NAME (Type) W. C. Brewer, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify) B.
22b. DATE THEREOF 3/4/59
22c. NAME OF CEMETERY OR CREMATORY Caseytown Cem.
22d. LOCATION (City, town, or county) Caseytown (State) Pa.

23. FUNERAL DIRECTOR'S SIGNATURE A. E. Mumma ADDRESS Greencastle, Pa.
24a. REC'D BY REGISTRAR DATE MAR 3
24b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03585

3589

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH
a. COUNTY: Washington
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 1 day
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Washington County Hospital

2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
d. STREET ADDRESS: 836 Rose Hill Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First GEORGE Middle FREDERICK Last BLOOM

4. DATE OF DEATH: Month March Day 7 Year 19 59

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: November 4, 1893

9. AGE (In years last birthday): 65 yrs

IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Grocerman

10b. KIND OF BUSINESS OR INDUSTRY: own business

11. BIRTHPLACE (State or foreign country): Hagerstown, Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Frederick Martin Bloom

14. MOTHER'S MAIDEN NAME: Mary Baker

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): NO

16. SOCIAL SECURITY NO.:

17. INFORMANT Address: Mrs. Mabel L. Bloom Hagerstown, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arterio sclerotic Heart Disease - Myocardial failure — INTERVAL BETWEEN ONSET AND DEATH: 5yrs
420.0
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Diabetes Mellitus

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year: Hour a. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Jan 52 to 7 Mar 59, that I last saw the deceased alive on 7 Mar 59, and that death occurred at 8.40 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: F F Lusby M.D.
ADDRESS (Street, city or town, state): 230 Potomac Hagerstown Md
DATE SIGNED: 7 Mar 59
PHYSICIAN'S NAME (Type): FFLusby

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 3/10/1959
22c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery
22d. LOCATION (City, town, or county) (State): Hagerstown, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Suter-Rouzer Funeral Home
ADDRESS: Hagerstown, Md.

24a. REC'D BY REGISTRAR DATE: MAR 11 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03586

3590

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 1 day
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Washington County Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Pennsylvania — b. COUNTY: Franklin
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Chambersburg
d. STREET ADDRESS: R.F.D. # 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Baby — Middle: Boy — Last: Brechbill

4. DATE OF DEATH: Month: March — Day: 21 — Year: 1959

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: March 20, 1959

9. AGE (In years last birthday) yrs: IF UNDER 1 YEAR: Months: — Days: 1 — IF UNDER 24 HRS: Hours: — Min:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Hagerstown, Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: He nry Brechbill

14. MOTHER'S MAIDEN NAME: Joann Dice

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service):

16. SOCIAL SECURITY NO: none

17. INFORMANT — Address: Mr. Henry Brechbill Chambersburg, Pa.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Atelectasis — INTERVAL BETWEEN ONSET AND DEATH:

762.5

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Prematurity

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Month, Day, Year; Hour: a. m. / p. m.

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from March 20, 19 59, to March 21, 19 59, that I last saw the deceased alive on March 21, 19 59, and that death occurred at 9:15 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: F. D. Doune Jr. M.D — ADDRESS (Street, city or town, state) — DATE SIGNED

PHYSICIAN'S NAME (Type):

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 3/23/1959

22c. NAME OF CEMETERY OR CREMATORY: New Guilford Cemetery

22d. LOCATION (City, town, or county) (State): New Guilford Pa.

23. FUNERAL DIRECTOR'S SIGNATURE: Parbour Funeral Home — ADDRESS: Chambersburg, Pa.

24a. REC'D BY REGISTRAR DATE: MAR 24 '59

24b. REGISTRAR'S SIGNATURE: Arthur L. Frank

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

208/10.3 X

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3591 **CERTIFICATE OF DEATH**

03587

Reg. Dist. No. 302

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 1 week
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Washington County Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
d. STREET ADDRESS: 704 Oak Hill Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First PHILIP — Middle HAMAKER — Last BREHM

4. DATE OF DEATH: Month March — Day 23 — Year 19 59

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: April 10, 1869

9. AGE (In years last birthday): 89 yrs

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Coffee Merchant

10b. KIND OF BUSINESS OR INDUSTRY: Self Employed

11. BIRTHPLACE (State or foreign country): Lancaster Co., Pa.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Philip W. Brehm

14. MOTHER'S MAIDEN NAME: Barbara Hamaker

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO: none

17. INFORMANT: Miss. Mildred Brehm — Address: Hagerstown, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 5 days
331X
DUE TO
(b): Arteriosclerosis - Generalized — Years.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Hemorrhage from large bowel

19. WAS A AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY: Hour — a. m. / p. m. — Month — Day — Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — 20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Mar 14, 1959, to March 23, 1959, that I last saw the deceased alive on March 23, 1959, and that death occurred at 4:55 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Lloyd A. Hoffman M.D. — ADDRESS (Street, city or town, state): 214 N Potomac St. — DATE SIGNED: 3/23/59

PHYSICIAN'S NAME (Type): Lloyd A. Hoffman — Hagerstown, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 3/26/1959

22c. NAME OF CEMETERY OR CREMATORY: Norland Cemetery

22d. LOCATION (City, town, or county) (State): Chambersburg, Pa.

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Hagerstown, Md.

24a. REC'D BY REGISTRAR DATE: MAR 26 '59

24b. REGISTRAR'S SIGNATURE: Catherine L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3592

CERTIFICATE OF DEATH

03588

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 7 weeks
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Western Maryland State Hospital

2. USUAL RESIDENCE (Where deceased lived If institution Res dence before admission)
a. STATE: Maryland — b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Williamsport Maryland RFD #1
d. STREET ADDRESS: Downsville
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First JOHN Middle WILLIAM Last BUHARP

4. DATE OF DEATH: Month MARCH Day 5 Year 1959

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: June 19 1879

9. AGE (In years last birthday): 79 yrs
IF UNDER 1 YEAR: Months 8 Days 14
IF UNDER 24 HRS: Hours Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Labor

10b. KIND OF BUSINESS OR INDUSTRY: Refrigerating Equipment

11. BIRTHPLACE (State or foreign country): Clearspring Md.

12. CITIZEN OF WHAT COUNTRY: U.S.A

13. FATHER'S NAME: William Buharp

14. MOTHER'S MAIDEN NAME: Betty Knavel

15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown): No (If yes, war or dates of service): No

16. SOCIAL SECURITY NO: 215 09 7335

17. INFORMANT: Mrs. Bessie Buharp Address: Downsville Williamsport Md RFD #1

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): LUNG ABSCESS LEFT UPPER LOBE — INTERVAL BETWEEN ONSET AND DEATH: 7 WEEKS

DUE TO (b): BRONCHOGENIC CARCINOMA OF LUNG — 2 YEARS

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from FEB. 2, 1959, to MAR. 5, 1959, that I last saw the deceased alive on MAR. 5, 1959, and that death occurred at 5:45 A.M., from the causes and on the date stated above

ACTUAL SIGNATURE: George Bercu M D
ADDRESS (Street, city or town, state): 1500 PENNSYLVANIA AVE HAGERSTOWN MARYLAND
DATE SIGNED: 3/5/59

PHYSICIAN'S NAME (Type): DR. GEORGE BERCU

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: March 8-59
22c. NAME OF CEMETERY OR CREMATORY: Greenlawn Cemetery
22d. LOCATION (City, town, or county) (State): Williamsport Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Elbert K Leaf ADDRESS: Williamsport, Maryland

24a. REC'D BY REGISTRAR DATE: MAR 9 '59
24b. REGISTRAR'S SIGNATURE: Arthur E. Krug

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3660

CERTIFICATE OF DEATH

Reg. Dist. No. 03589

1 PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cascade
c. LENGTH OF STAY IN 1b: 9 mos.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Hawn Convalescent Home

2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission)
a. STATE: Penna. — b. COUNTY: Franklin ✓
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Waynesboro
d. STREET ADDRESS: 121 Harrison Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First ELBERTIE Middle — Last CONRAD

4. DATE OF DEATH: Month March — Day 21 — Year 1959

5 SEX: Female
6 COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8 DATE OF BIRTH: Mar. 18, 1871
9 AGE (In years last birthday): 88 yrs
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: own home
11. BIRTHPLACE (State or foreign country): Fayetteville, Penna.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William Brookens
14. MOTHER'S MAIDEN NAME: Jane Dehart

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): No
16 SOCIAL SECURITY NO.: None
17. INFORMANT: Frank F. Conrad, 113 N. Franklin St. — Address Waynesboro, Penna.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Arteriosclerosis in Cardio Vascular Renal — INTERVAL BETWEEN ONSET AND DEATH: 12 years

DUE TO (b): Old Age — 15 years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year, Hour a. m. p. m. 19
20d INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from March 18, 1959 to March 21, 1959 that I last saw the deceased alive on March 21, 1959, and that death occurred at 9:30 A.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: Roland A. Thomas, M.D. — ADDRESS (Street, city or town, state): Blue Ridge Summit, Pa. — DATE SIGNED: 22 Mar 59

PHYSICIAN'S NAME (Type):

22a BURIAL, CREMATION, REMOVAL (Specify): Burial
22b DATE THEREOF: Mar. 24, 1959
22c. NAME OF CEMETERY OR CREMATORY: Green Hill Cemetery
22d LOCATION (City, town, or county) (State): Waynesboro, Penna.

23. FUNERAL DIRECTOR'S SIGNATURE: H. Marlin Doe — ADDRESS: Waynesboro, Penna.
24a REC'D BY REGISTRAR DATE: MAR 24 '59
24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3593 **CERTIFICATE OF DEATH** 03590

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 5 days
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: Washington County Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
d. STREET ADDRESS: 1408 Sherman Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Jay — Middle Richard — Last Coons

4. DATE OF DEATH: Month March — Day 28 — Year 19 59

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Mar. 22, 1959

9. AGE (In years last birthday) yrs — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): Hagerstown Md.

12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: Joseph R. Coons

14. MOTHER'S MAIDEN NAME: Virginia Henry

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): —
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: —

17. INFORMANT: Mrs. Virginia Coons — Address: Hagerstown Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Premature birth — INTERVAL BETWEEN ONSET AND DEATH: 5 days
DUE TO
(b)
DUE TO
(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

116X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from March 22, 1959, to March 28, 1959, that I last saw the deceased alive on March 28 1959, and that death occurred at 4:00 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: L L Packer M.D. — ADDRESS (Street, city or town, state): 145 W. Washington — DATE SIGNED: 3/28/59

PHYSICIAN'S NAME (Type): L. L. Packer Jr. M.D. Hagerstown, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 3-28-59

22c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery

22d. LOCATION (City, town, or county) (State): Hagerstown Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Scott F. Minnich & Son — ADDRESS: Hagerstown Md.

24a. REC'D BY REGISTRAR DATE: MAR 30 '59

24b. REGISTRAR'S SIGNATURE: Evelyn S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03591

3594 **CERTIFICATE OF DEATH**

Reg. Dist. No. 302

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 2 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Washington County Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)
a. STATE: Maryland — b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Tilghmanton
d. STREET ADDRESS: Fairplay R.F.D. #1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First CHARLES — Middle WILMER — Last DAVIS

4. DATE OF DEATH: Month March — Day 15 — Year 1959

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: September 23, 1899
9. AGE (In years last birthday): 59 yrs
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10b. KIND OF BUSINESS OR INDUSTRY: aircraft company
11. BIRTHPLACE (State or foreign country): Tilghmanton
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Edward L. Davis
14. MOTHER'S MAIDEN NAME: Julia Rohrer

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT — Address: Mrs. Rosie M. Davis Tilghmanton, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 1 Day
DUE TO
420.1
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year, Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 3/15/59, 19____, to 3/15/59, 19____, that I last saw the deceased alive on 3/15/59, 19____, and that death occurred at ____ M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Ralph Young M.D. — ADDRESS (Street, city or town, state): Williamsport, Md. — DATE SIGNED: 3/16/59

PHYSICIAN'S NAME (Type): Dr. Ralph Young

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 3/18/1959
22c. NAME OF CEMETERY OR CREMATORY: Manor Cemetery
22d. LOCATION (City, town, or county) (State): Tilghmanton, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Suter-Rouzer Funeral Home — ADDRESS: Hagerstown, Md.
24a. REC'D BY REGISTRAR DATE: MAR 18 '59
24b. REGISTRAR'S SIGNATURE: Arthur L. Hawk

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3595

CERTIFICATE OF DEATH

Reg. Dist. No. 03592

1. PLACE OF DEATH
a. COUNTY Washington MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown
c. LENGTH OF STAY IN 1b —
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Garlock Memorial Home

2. USUAL RESIDENCE (Where deceased lived If institution, residence before admission)
a. STATE Pa. b. COUNTY Franklin
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chambersburg
d. STREET ADDRESS 397 2nd ST.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First Emma Middle Young Last Davison
4. DATE OF DEATH Month March Day 6 Year 1959

5. SEX F
6. COLOR OR RACE W
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH 1/7/1869
9. AGE (In years last birthday) 90 yrs
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS Hours Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper
10b. KIND OF BUSINESS OR INDUSTRY Home
11. BIRTHPLACE (State or foreign country) Franklin Co, Pa.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME John Brown Davison
14. MOTHER'S MAIDEN NAME Martha Young

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. —
17. INFORMANT Address John D. Davison — Chambersburg Pa.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute coronary occlusion (presumptive) — INTERVAL BETWEEN ONSET AND DEATH Few minutes

DUE TO (b) Arteriosclerotic Heart Disease — Unknown

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 420.0

DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Hypertension — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Hour a. m. p. m. Month Day Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 3/1, 19 59 (Only Twice) that I last saw the deceased alive on 3/1, 19 59, and that death occurred at 8:00 A.M. from the causes and on the date stoted above.

ACTUAL SIGNATURE J H Hornbaker M.D. ADDRESS (Street, city or town, state) 154 West Washington St., DATE SIGNED 3-6-59

PHYSICIAN'S NAME (Type) John H. Hornbaker, M.D. Hagerstown, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify) Bl.
22b. DATE THEREOF 3/9/1959
22c. NAME OF CEMETERY OR CREMATORY Cedar Hill
22d. LOCATION (City, town, or county) (State) Greencastle, Pa.

23. FUNERAL DIRECTOR'S SIGNATURE A.S. Mumma ADDRESS Greencastle
24a. REC'D BY REGISTRAR DATE MAR 9 '59
24b. REGISTRAR'S SIGNATURE Arthur L. Kime

74.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3596 CERTIFICATE OF DEATH

03593
Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 2½ hrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Wash. Co. Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Md. — b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
d. STREET ADDRESS: 935 W. Wash. St.,
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Harry — Middle: Charles — Last: Dorsey
4. DATE OF DEATH: Month: 3 — Day: 30 — Year: 19 59
5. SEX: male
6. COLOR OR RACE: white
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Dec. 28, 1890
9. AGE (In years last birthday): 68 yrs
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): retired
10b. KIND OF BUSINESS OR INDUSTRY: Bester Long Co.
11. BIRTHPLACE (State or foreign country): Washington Co. Md.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Edward Dorsey
14. MOTHER'S MAIDEN NAME: Sarah Danner

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 217-12-2830
INFORMANT: Mrs. Annie C. Dorsey — Address: Hagerstown, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: One week
420.1
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Diabetes
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Month, Day, Year; Hour: o. m. / p. m.
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Aug 27 — 19 57, to Mar 30 — 19 59, that I last saw the deceased alive on May 30 — 19 59, and that death occurred at 1:40 P.M., from the causes and on the date stated above.
ACTUAL SIGNATURE: W. D. Campbell M.D. — ADDRESS (Street, city or town, state) — DATE SIGNED: Mar 31 — 1959
PHYSICIAN'S NAME (Type): W. D. CAMPBELL

22a. BURIAL, CREMATION, REMOVAL (Specify): burial
22b. DATE THEREOF: 4-2-59
22c. NAME OF CEMETERY OR CREMATORY: Rose Hill
22d. LOCATION (City, town, or county) (State): Hagerstown Md.

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Fred W. Kraiss Hagerstown, Md.
24a. REC'D BY REGISTRAR — DATE: APR 2 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Kraiss

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH--BALTIMORE, 18

03594

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

3597

Reg. Dist. No. 302

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 14 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 731 Dale Street

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
d. STREET ADDRESS: 731 Dale Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First LUIA Middle ELLA Last DRURY

4. DATE OF DEATH: Month March Day 10 Year 19 59

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: March 17,1884

9. AGE (In years last birthday): 74 yrs
IF UNDER 1 YEAR: Months ___ Days ___
IF UNDER 24 HRS: Hours ___ Min ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Hagerstown, Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Cornelius Davis

14. MOTHER'S MAIDEN NAME: Evaline Virginia Brenner

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: none

17. INFORMANT: Mrs. John Worthington — Address: Hagerstown, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Burns to entire body, head & extremities (Charring)

916.0

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): None

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18): Clothing caught fire when can with gasoline in it exploded

20c. TIME OF INJURY: Hour 5:00 P m. Month, Day, Year March 10 '59

20d. INJURY OCCURRED: While at work ☐ Not while at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Home

20f. (City or town) Hagerstown (County) Wash (State) Md

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: S. Robert Wells, M.D.

EXAMINER'S NAME (Type): S. Robert Wells, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED: March 11,1959

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 3/13/1959

22c. NAME OF CEMETERY OR CREMATORY: Rest Haven Cemetery

22d. LOCATION (City, town, or county) Hagerstown (State) Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Suter-Rouzer Funeral Home

ADDRESS: Hagerstown, Maryland

24a. REC'D BY REGISTRAR DATE: MAR 16 '59

24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15ME
5M 2/57

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be completed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03595

3593

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 10 years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): 323 Ridge Ave,

2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission)
a. STATE: Maryland — b COUNTY: Washington
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
d STREET ADDRESS: 323 Ridge Ave.
e IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First HOWARD — Middle LEE — Last EICHELBERGER

4. DATE OF DEATH: Month March — Day 13 — Year 19 59

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: April 5, 1912

9. AGE (In years last birthday): 46 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Electrical Foreman

10b. KIND OF BUSINESS OR INDUSTRY: Railroad

11. BIRTHPLACE (State or foreign country): Hagerstown, Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John L. Eichelberger

14. MOTHER'S MAIDEN NAME: Rhoda Shrader

15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO: 214-10-4268

17. INFORMANT: Mrs. Luvada Eichelberger — Address: Hagerstown, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH
420.1
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): none

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.): none

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year: none 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐ ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): none

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: S. Robert Wells M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 3-14-59

EXAMINER'S NAME (Type): S. Robert Wells, M.D.

22a. BURIAL CREMATION REMOVAL (Specify): Burial
22b. DATE THEREOF: 3/16/1959
22c. NAME OF CEMETERY OR CREMATORY: Cedar Lawn Cemetery
22d. LOCATION (City, town, or county) (State): Hagerstown, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Suter-Louzer Funeral Home
ADDRESS: Hagerstown, Md.

24a. REC'D BY REGISTRAR DATE: MAR 18 '59

24b. REGISTRAR'S SIGNATURE: Arthur L. Kramer

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 3 altered 3-14-59 et

3599

CERTIFICATE OF DEATH

Reg. Dist. No. 03596

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 5 yrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Western Md. State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Tillman's Island
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First META Middle G Last Etheridge

4. DATE OF DEATH: Month March Day 13 Year 1959

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: March 16, 1886

9. AGE (In years last birthday): 73 yrs. 14

IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Tillman's Island Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Jacob Gibson

14. MOTHER'S MAIDEN NAME: Anna Ann Miller

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 216-22-4672

17. INFORMANT: Raymond Etheridge, Jr. Address: Rocky Ridge, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a): CEREBRAL HEMORRHAGE — INTERVAL BETWEEN ONSET AND DEATH: 30 MINUTES

4431

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): HYPERTENSIVE CARDIO-VASCULAR DISEASE — 9 YEARS

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): ARTERIOSCLEROSIS, GENERAL. PNEUMONIA

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY: Hour a. m. / p. m. Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from July 3, 1958, to MARCH 13, 1959, that I last saw the deceased alive on MARCH 13, 1959, and that death occurred at 2:00 PM, from the causes and on the date stated above.

ACTUAL SIGNATURE: Evaristo R Lardizabal M.D. ADDRESS (Street, city or town, state): 1500 PENNSYLVANIA AVE DATE SIGNED: 3-13-59

PHYSICIAN'S NAME (Type): Evaristo R. Lardizabal Hagerstown Md

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 3-17-59

22c. NAME OF CEMETERY OR CREMATORY: St. Anthony Cemetery

22d LOCATION (City, town, or county) (State): nr. Emmitsburg, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Raymond E. Keegan ADDRESS: Thurmont Md

24a. REC'D BY REGISTRAR DATE: MAR 17 '59

24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3661

CERTIFICATE OF DEATH

03597

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Washington
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Williamsport
c. LENGTH OF STAY IN 1b: Since birth

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
d. STREET ADDRESS: 230 N. Potomac St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Williamsport Sanitarium

3. NAME OF DECEASED (Type or print): First Mayne Middle Peck Last Farrier

4. DATE OF DEATH: Month March Day 12 Year 1959

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☑ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: November 14, 1875
9. AGE (In years last birthday): 83 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Govt worker
10b. KIND OF BUSINESS OR INDUSTRY: Acct.
11. BIRTHPLACE (State or foreign country): Sinking Creek, Va.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William Farrier
14. MOTHER'S MAIDEN NAME: Elizabeth Vaughan

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO: None
17. INFORMANT: Dr. Frank Lusby Address 1601 Fountain Hgd. Rd. Hagerstown, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 2 weeks
DUE TO (b): Arteriosclerotic Hypertensive Cardiovascular Disease — 10 yrs +
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month Day Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 27 Feb 1959 to 12 Mar 1959, that I last saw the deceased alive on 12 Mar 1959, and that death occurred at 1:30 P.M., from the causes and on the date stated above

ACTUAL SIGNATURE: F F Lusby M.D.
ADDRESS (Street, city or town, state): 230 N Potomac St Hagerstown Md
DATE SIGNED: 12 14 59
PHYSICIAN'S NAME (Type): F F Lusby

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 3/14/59
22c. NAME OF CEMETERY OR CREMATORY: Evergreen Burial Park
22d. LOCATION (City, town, or county): Roanoke (State): Va.

23. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: Rest Haven Funeral Chapel Hagerstown Md.
24a. RECEIVED BY REGISTRAR DATE: MAR 16 '59
24b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 must be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3600 Item 7 FilmG240 4-2-59 et

CERTIFICATE OF DEATH

03598

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 9/58

1. PLACE OF DEATH a. COUNTY: Wash. MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Md. b. COUNTY: Wash.
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown; c. LENGTH OF STAY IN 1b:	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 3 Hagerstown
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 34 W. Franklin St.,	d. STREET ADDRESS: 34 W. Franklin St., e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
John	C	Feigley	3	14	1959

5. SEX	6. COLOR OR RACE	7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS Hours	Min
male	white		July 7, 1915	43 yrs				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
electrician	Fairchilds	Hagerstown, Md.	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
William K. Feigley	Dora E. Wilson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	INFORMANT	Address
yes	II	213-16-1599	Bernard Feigley	Hagerstown, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Coronary Occlusion. — INTERVAL BETWEEN ONSET AND DEATH: 6 weeks

4 1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

DUE TO (b):

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): None.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work ☐ Not while at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Feb. 6, 1959 to March 4, 1959 that I last saw the deceased alive on March 4, 1959, and that death occurred at ? M, from the causes and on the date stated above.

ACTUAL SIGNATURE: R. A. Bell M.D. — ADDRESS (Street, city or town, state): 119 North Potomac St., — DATE SIGNED: 3-17-59.

PHYSICIAN'S NAME (Type): R. A. Bell, M. D. — Hagerstown, Maryland.

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	3-19-59	Rose Hill	Hagerstown Md.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS	24a. REC'D BY REGISTRAR DATE	24b. REGISTRAR'S SIGNATURE
Fred W. Kraiss Hagerstown, Md.	MAR 20 '59	Arthur S. Krause

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 14 Filed 3-11-59 et

3662

CERTIFICATE OF DEATH

Reg. Dist. No. 03599

1 PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): rural Hagerstown
c. LENGTH OF STAY IN 1b: 2 weeks
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Gateway Conv. Home

2 USUAL RESIDENCE (Where deceased lived If institution: Residence before admission)
a. STATE: Md. — b. COUNTY: Wash.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
d. STREET ADDRESS: 604 W. Washington St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First Ellis — Middle — Last Fincham

4. DATE OF DEATH: Month March — Day 6, — Year 1959

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: April 15, 1880

9. AGE (In years last birthday): 78 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): laborer

10b. KIND OF BUSINESS OR INDUSTRY: general work

11. BIRTHPLACE (State or foreign country): Rappahanock, Va.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Preston Fincham

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 220-10-3595

17. INFORMANT — Address: Mrs. Minnie Roberts, Hagerstown, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cardiac Arrest — INTERVAL BETWEEN ONSET AND DEATH: Min

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

(b): Auricular Fibrillation — Day

DUE TO

(c): Arteriosclerosis — Yrs

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Bronchitis, Chronic, Pulmonary

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Feb 25, 19 59, to Mar 6, 19 59, that I last saw the deceased alive on Mar 5, 19 59, and that death occurred at 5:20 M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Louis C. Craft, M.D. — ADDRESS (Street, city or town, state): 119 E. Antietam St. Hagerstown, Md. — DATE SIGNED

PHYSICIAN'S NAME (Type): Louis C. Craft

22a. BURIAL, CREMATION, REMOVAL (Specify): burial

22b. DATE THEREOF: 3-9-59

22c. NAME OF CEMETERY OR CREMATORY: Smoketown Cemetery

22d. LOCATION (City, town, or county) (State): Martinsburg, W.Va.

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Scott F. Minnich & Son, Hagerstown, Md.

24a. REC'D BY REGISTRAR DATE MAR 9 '59

24b. REGISTRAR'S SIGNATURE: Arthur L. Kaufman

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 shall be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 shall be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

FOR STATE HEALTH DEPT.

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

3601

036000

Reg. Dist No. 302

1. PLACE OF DEATH
a. COUNTY Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Hagerstown
c. LENGTH OF STAY IN 1b: 11 Yrs
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 1031 Corbett St

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland — b. COUNTY Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ~2 Hagerstown
d. STREET ADDRESS: 1031 Corbett St
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First EZRA — Middle ——— — Last FOX

4. DATE OF DEATH: Month March — Day 25 — Year 1959

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ W DOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Oct 10 1867

9. AGE (In years last birthday): 91 yrs.

IF UNDER 1 YEAR: Months — Days

IF UNDER 24 HRS: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Grocery Merchant

10b. KIND OF BUSINESS OR INDUSTRY: Retired

11. BIRTHPLACE (State or foreign country): Leitersburg Wash. Co Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Levi Fox

14. MOTHER'S MAIDEN NAME: Barbara Hershey

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): ———

16. SOCIAL SECURITY NO: None

17. INFORMANT: Eston Fox — Address: Funkstown Wash. Co Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Generalized arteriosclerosis(Vascular)
DUE TO (b): Acute Coronary thrombosis
DUE TO (c): ———

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): None

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18): none

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year: none 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): none

20f. (City or town) — (County) — (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: S. Robert Wells M.D

EXAMINER'S NAME (Type): S. Robert Wells, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED: 3-27-59

22a. BURIAL CREMATION REMOVAL (Specify): Burial

22b. DATE THEREOF: 3/25/59

22c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery

22d. LOCATION (City, town, or county): Hagerstown Wash. Co (State) Md

23. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: Andrew K. Coffman Hagerstown Md.

24b. REC'D BY REGISTRAR DATE: MAR 31 '59

24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

036111

3663

CERTIFICATE OF DEATH

Reg. Dist. No. 3

1. PLACE OF DEATH
a. COUNTY: Wash. Co. MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown Rural
c. LENGTH OF STAY IN Jb: 1 week.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Valley Convalescent Home

2. USUAL RESIDENCE (Where deceased lived If institution, Residence before admission)
a. STATE: Penna.
b. COUNTY: Franklin
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chambersburg R.F.D. 3
d. STREET ADDRESS: 454 E. Queen St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Solomon Middle G. Last Franklin

4. DATE OF DEATH: Month Mar. Day 9 Year 1959

5. SEX: Male
6. COLOR OR RACE: W.
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Sept 22, 1872
9. AGE (In years last birthday) 86 yrs
IF UNDER 1 YEAR: Months ___ Days ___
IF UNDER 24 HRS: Hours ___ Min ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired machinist
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Penna.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Levi Franklin
14. MOTHER'S MAIDEN NAME: Margaret Gabler

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 192-14-6095
17. INFORMANT: Mrs. Nellie Kauffman Address: 451 E Queen St. Chambersburg, Pa.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arterio Sclerotic Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: 1 yr.

11-20.0

DUE TO (b)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Hypertrophy of Prostate & Obstruction

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year, Hour o. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Mar 3, 19 59 to Mar 9, 19 59 that I last saw the deceased alive on Mar 8, 19 59, and that death occurred at 11:30 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: David R. Brewer M.D. ADDRESS (Street, city or town, state): David R. Brewer DATE SIGNED: 3/10/59

PHYSICIAN'S NAME (Type): David R. Brewer Silver Spring Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 3/12/59
22c. NAME OF CEMETERY ~~OR CREMATORY~~: Cedar Grove
22d. LOCATION (City, town, or county) (State): Chambersburg, Pa.

23. FUNERAL DIRECTOR'S SIGNATURE: Robert C. Barton ADDRESS: Chambersburg, Pa.
24a. REC'D BY REGISTRAR DATE MAR 16 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3602 CERTIFICATE OF DEATH

03602
Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: WASHINGTON — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAGERSTOWN
c. LENGTH OF STAY IN 1b: LIFE
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: WASHINGTON COUNTY HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: WASHINGTON
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAGERSTOWN
d. STREET ADDRESS: 1621 VIRGINIA AVE.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First EVA — Middle LENA — Last FUNKHOUSER

4. DATE OF DEATH: Month MARCH — Day 22 — Year 19 59

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 3/28/1887

9. AGE (In years last birthday): 71 yrs.

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE

10b. KIND OF BUSINESS OR INDUSTRY: HOME

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: WILLIAM A. HOSE

14. MOTHER'S MAIDEN NAME: MARY ELIZABRTH BAUGHMAN

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown) (If yes, give war or dates of service): NO

16. SOCIAL SECURITY NO: NONE

17. INFORMANT: MR. THOMAS J. FUNKHOUSIR — Address: HAGERSTOWN MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): 331X — INTERVAL BETWEEN ONSET AND DEATH: 16 hr.

DUE TO (b): Cerebral hemorrhage — Indefinite

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c): Hypertensive vascular disease

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour o. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from _____, 19 40 to March 22, 1959, that I last saw the deceased alive on March 22, 1959, and that death occurred at 2P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: B B Kneisley M.D. — ADDRESS (Street, city or town, state): 148 West Washington St. Hagerstown, Maryland — DATE SIGNED: 3/24/59

PHYSICIAN'S NAME (Type): Dr. B. B. Kneisley

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: 3/25/59

22c. NAME OF CEMETERY OR CREMATORY: REST HAVEN CEM.

22d. LOCATION (City, town, or county) (State): HAGERSTOWN MD.

23. FUNERAL DIRECTOR'S SIGNATURE: W. L. Normentt, Hagerstown Md. — ADDRESS:

24a. REC'D BY REGISTRAR — DATE: MAR 26 '59

24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. [illegible] page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in [illegible] the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and [illegible] should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS AIS (4) ISM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3603 CERTIFICATE OF DEATH

Reg. Dist. No 03603

1. PLACE OF DEATH
a. COUNTY: WASHINGTON — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAGERSTOWN
c. LENGTH OF STAY IN 1b: 39 YRS.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: WASHINGTON COUNTY HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MATYLAND — b. COUNTY: WASHINGTON
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAGERSTOWN
d. STREET ADDRESS: 759 S. POTOMAC ST.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: IRVING — Middle: — Last: GARRETT

4. DATE OF DEATH: Month: MARCH — Day: 26 — Year: 19 59

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 1/10/1885

9. AGE (In years last birthday): 74 yrs
IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED SEXTON

10b. KIND OF BUSINESS OR INDUSTRY: BOARD OF EDUCATION

11. BIRTHPLACE (State or foreign country): VIRGINIA

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: DAVID GARRETT

14. MOTHER'S MAIDEN NAME: MOLLIE EASTHAM

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): NO (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 216-22-7617

17. INFORMANT: MRS. PAULINE WAGNER — Address: HAGERSTOWN MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Ruptured gastric ulcer — INTERVAL BETWEEN ONSET AND DEATH: 24 hours

540.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:
DUE TO (b): Bronchopneumonia
DUE TO (c): Diabetes mellitus

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Chronic cistopielitis

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY: Month, Day, Year; Hour a. m. p. m.; 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that I attended the deceased from 3-24-, 1959, to 3-26-, 1959, that I last saw the deceased alive on 3-26-, 1959, and that death occurred at 10 A M, from the causes and on the date stated above.

SIGNATURE: Joseph Secondari M.D. — ADDRESS (Street, city or town, state): 21 MAIN Street Boonsboro Md. — DATE SIGNED

PHYSICIAN'S NAME (Type): JOSEPH SECONDARI — 3/26/59

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 3/29/59
22c. NAME OF CEMETERY OR CREMATORY: REST HAVEN CEM.
22d. LOCATION (City, town, or county) (State): HAGERSTOWN MD.

23. FUNERAL DIRECTOR'S SIGNATURE: W. T. Norment — ADDRESS: Hagerstown, Md.

24a. REC'D BY REGISTRAR: DATE MAR 30 '59

24b. REGISTRAR'S SIGNATURE: Adelma E. Evans

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03604

3604

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1 PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 1 year
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 1110 Fry Ave.

2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
d STREET ADDRESS: 1110 Fry Ave.
e IS RESIDENCE ON A FARM: YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First SARAH Middle LAVINIA Last GRANTLAND

4 DATE OF DEATH: Month March Day 9 Year 1959

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8 DATE OF BIRTH: September 27, 1875

9 AGE (In years last birthday): 83 yrs

IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min.

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b KIND OF BUSINESS OR INDUSTRY:

11 BIRTHPLACE (State or foreign country): Wilmington, Delaware

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Jacob Andrew Perwar

14. MOTHER'S MAIDEN NAME: Margaret Coulbourne

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) none (If yes, give war or dates of service)

16. SOCIAL SECURITY NO: none

17 INFORMANT: Mr. George E. Grantland Address: Hagerstown, Maryland

MEDICAL CERTIFICATION

18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Congestive Heart Failure — INTERVAL BETWEEN ONSET AND DEATH: 1 mo
DUE TO (b): Arteriosclerotic heart disease — 5 yrs
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

I420.0

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that I attended the deceased from 7.20.57, 19____, to 3.9.59, 19____, that I last saw the deceased alive on 3.8.59, 19____, and that death occurred at 10:55 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Earl Young M.D. ADDRESS (Street, city or town, state): 145 W. Potomac St. Hagerstown DATE SIGNED: 3/10/59

PHYSICIAN'S NAME (Type): S. EARL YOUNG M.D.

22a BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 3/12/59

22c. NAME OF CEMETERY OR CREMATORY: Lombardy Cemetery

22d LOCATION (City, town, or county) (State): Wilmington, Delaware

23. FUNERAL DIRECTOR'S SIGNATURE: Suter-Rouzer Funeral Home ADDRESS: Hagerstown, Maryland

24a REC'D BY REGISTRAR DATE: MAR 16 59

24b. REGISTRAR'S SIGNATURE: Clinton L. Travis

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

3605 — Reg. Dist. No. 03605

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 4 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Wash Co Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
d. STREET ADDRESS: 503 S Potomac
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First: Bethe — Middle: Virginia — Last: Greenburn

4. DATE OF DEATH: Month: March — Day: 2 — Year: 1959

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: April 20, 1918

9. AGE (In years last birthday): 40 yrs — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): W.Va.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Cecil Feaster

14. MOTHER'S MAIDEN NAME: Leonara Rexroad

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT: Retha Bricker-Hagerstown, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Left ventricle heart failure due — INTERVAL BETWEEN ONSET AND DEATH: 3 days

DUE TO (b): Pneumonia. — 3 days

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c): Bronchiectosis — Years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Emaciation

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Feb 15, 1959, to March 2, 1959, that I last saw the deceased alive on March 1, 1959, and that death occurred at 6:35 AM, from the causes and on the date stated above

ACTUAL SIGNATURE: Eldon S Hoochlank M.D. — ADDRESS (Street, city or town, state): 115 W Wash St Hagerstown Md — DATE SIGNED: Mar 2 59

PHYSICIAN'S NAME (Type): Eldon S Hoochlank

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 22b. DATE THEREOF: 3/4/59 — 22c. NAME OF CEMETERY OR CREMATORY: Philos — 22d. LOCATION (City, town, or county) (State): Westernport, Md

23. FUNERAL DIRECTOR'S SIGNATURE: E L Beall — ADDRESS: Westernport, Md.

24a. REC'D BY REGISTRAR DATE: MAR 5 '59 — 24b. REGISTRAR'S SIGNATURE: Arthur S. Kinna

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

3664 Items 16,22c Filed 3-6-59 et

03606
Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Edgemont Rural, Smithsburg #2
c. LENGTH OF STAY IN 1b: Life
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md. b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Rural, Smithsburg #2, Edgemont
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Julia Middle Elizabeth Last Grotz
4. DATE OF DEATH: Month March Day 8, Year 19 59
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 5/16/1894
9. AGE (In years last birthday): 64 yrs. IF UNDER 1 YEAR: Months, Days. IF UNDER 24 HRS.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Greensburg Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Benton Schull
14. MOTHER'S MAIDEN NAME: Alice Cornell
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 214-32-4034
17. INFORMANT Address: Edward H. Schull, Smithsburg Md., #1

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): — INTERVAL BETWEEN ONSET AND DEATH:
4 ×
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Cerebral Hemorrhage — instant
DUE TO (c): La Grippe — 10 days

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour, a. m. p. m., Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: [signature] M.D.
EXAMINER'S NAME (Type): DEWITT C. [illegible]
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 3/9/59

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 3/11/59
22c. NAME OF CEMETERY OR CREMATORY: Weltys Cemetery Strong's
22d. LOCATION (City, town, or county) (State): Smithsburg, Maryland Fayetteville, Franklin Pa. #2
23. FUNERAL DIRECTOR'S SIGNATURE: Walter Y. Hart ADDRESS: [illegible]
24a. REC'D BY REGISTRAR DATE: MAR 11 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give reasons in Item 27, Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3606

CERTIFICATE OF DEATH

03607

Reg. Dist. No. 03

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: D.O.A.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Wash. County Hospital

2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 03 Hagerstown
d. STREET ADDRESS: 16 Cypress St
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First PAUL Middle EMERSON Last GRUBER

4. DATE OF DEATH: Month March Day 27 Year 19 59

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Nov. 17 1893

9. AGE (In years last birthday): 65 yrs
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS: Hours Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Merchant

10b. KIND OF BUSINESS OR INDUSTRY: Mens Furnishing

11. BIRTHPLACE (State or foreign country): Hagerstown Wash. Co Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: George M. Gruber

14. MOTHER'S MAIDEN NAME: Louisa Winch

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): Yes (If yes, give war or dates of service): W.W. # 1

16. SOCIAL SECURITY NO:

17. INFORMANT: Mrs Ann Gruber Address: 16 Cypress St Hagerstown Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: minutes
DUE TO
(b): Arteriosclerotic Heart Disease — 3 yrs
DUE TO
(c):

420.0

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that I attended the deceased from Sept. 1956, to March 27, 1959, that I last saw the deceased alive on March 27, 1959, and that death occurred at 10:30 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Floyd A. HoFFman M.D. ADDRESS (Street, city or town, state): 214 N. Potomac St DATE SIGNED: 3/28/59

PHYSICIAN'S NAME (Type): Lloyd A. HoFFman Hagerstown, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 3/30/59
22c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery
22d LOCATION (City, town, or county) (State): Hagerstown Wash. Co Md.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Andrew K. Coffman Hagerstown Md.

24a. REC'D BY REGISTRAR DATE: MAR 31 '59

24b REGISTRAR'S SIGNATURE: Arthur L. Friend

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 10/57

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3665

CERTIFICATE OF DEATH

03608

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY Washington MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Clearspring R.D.1
c. LENGTH OF STAY IN 1b 14 Months
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Gateway Convalescent Home Inc.

2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission)
a. STATE Penna.
b. COUNTY Franklin ✓
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Waynesboro
d. STREET ADDRESS 430 Fairview Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First Ada Middle Florence Last Harbaugh

4. DATE OF DEATH Month Mar Day 21. Year 1959

5. SEX Female

6. COLOR OR RACE white

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH 4/17/1878

9. AGE (In years last birthday) 80 yrs
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS Hours Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Sabillasville, Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Comenius Pryor

14. MOTHER'S MAIDEN NAME Josephine Pryor

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Address Roscoe Pryor 34 W. Main St. Waynesboro, Pa.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Chr. Cardio Vascular Dis — INTERVAL BETWEEN ONSET AND DEATH 15 mo
DUE TO (b) Arterio Sclerosis — 10 yrs.
DUE TO (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 422.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Feb. 19, 1958 to Mar 21, 1959 that I last saw the deceased alive on Mar 20, 1959, and that death occurred at 10.40 M, from the causes and on the date stated above.

ACTUAL SIGNATURE David R Brewer M.D. ADDRESS (Street, city or town, state) Box 206 DATE SIGNED 3/22/59

PHYSICIAN'S NAME (Type) David R. Brewer Clear Spring Md.

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial

22b. DATE THEREOF 3/24/59

22c. NAME OF CEMETERY OR CREMATORY Burns Hill

22d. LOCATION (City, town, or county) (State) Waynesboro, Pa.

23. FUNERAL DIRECTOR'S SIGNATURE Nellie L Grove ADDRESS Waynesboro, Pa.

24a. REC'D BY REGISTRAR DATE MAR 26 '59

24b. REGISTRAR'S SIGNATURE Arthur S. Krause

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3607

CERTIFICATE OF DEATH

Reg. Dist. No. 0360:

1 PLACE OF DEATH
a COUNTY: Washington — MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c LENGTH OF STAY IN 1b: 2 days
d NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION: Wash. Co. Hospital

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md. b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 03 Hagerstown
d STREET ADDRESS: 109 Fairground Ave.,
e IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Guy — Middle: W — Last: Harbaugh
4. DATE OF DEATH: Month: 3 — Day: 25 — Year: 19 59
5 SEX: male
6. COLOR OR RACE: white
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: May 30, 1898
9. AGE (In years last birthday): 60 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): accountant
10b KIND OF BUSINESS OR INDUSTRY: self employed
11. BIRTHPLACE (State or foreign country): Woodsboro, Md.
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Clayton B Harbaugh
14 MOTHER'S MAIDEN NAME: Alberta Eyler

15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)
16 SOCIAL SECURITY NO.: 220-09-7160
INFORMANT: Katherine Harbaugh — Address: Hagerstown, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Coronary thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 48 hours

DUE TO (b): Pneumonia — 5 days

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c): Toxic thyroid diffuse Poliomyelitis old, with severe deformity since childhood — indefinite

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): 081X

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year, Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that I attended the deceased from 3-24-59, 1956 to death, 19___, that I last saw the deceased alive on 3-24-59, 19___, and that death occurred at 8:25 M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Robert F. Keadle M.D. — ADDRESS (Street, city or town, state): 318 North Potomac Street, Hagerstown, Md. — DATE SIGNED: 3-25-59

PHYSICIAN'S NAME (Type): Robert F. Keadle

22a BURIAL, CREMATION, REMOVAL (Specify): burial
22b DATE THEREOF: 3-28-59
22c. NAME OF CEMETERY OR CREMATORY: Rest Haven
22d. LOCATION (City, town, or county) (State): Hagerstown Md.

23 FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Fred W. Kraiss Hagerstown, Md.

24a. REC'D BY REGISTRAR DATE: MAR 26 '59
24b REGISTRAR'S SIGNATURE: Arthur L. Frank

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3608 CERTIFICATE OF DEATH

Reg. Dist. No. 03616

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: Life
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 826 S. Potomac St.

2 USUAL RESIDENCE (Where deceased lived — If institution, Residence before admission)
a. STATE: Maryland — b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
d. STREET ADDRESS: 826 S. Potomac St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Lee — Middle: Ragan — Last: Harrison

4. DATE OF DEATH: Month: March — Day: 1 — Year: 1959

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: August 24, 01

9. AGE (In years last birthday): 57 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Superintendent

10b. KIND OF BUSINESS OR INDUSTRY: Steel Fabrication

11. BIRTHPLACE (State or foreign country): Hagerstown Md.

12. CITIZEN OF WHAT COUNTRY: U. S. A.

13. FATHER'S NAME: David F. Harrison

14. MOTHER'S MAIDEN NAME: Minnie L. Lewis

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): ---- (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 214-09-0930

17. INFORMANT: Mrs. Louise S. Harrison — Address: Hag. Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: 5 minutes
DUE TO
(b): Arteriosclerotic Heart Disease — 3 yrs
DUE TO
(c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

420.0

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour o. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Dec 2nd, 1946, to March 1st, 1959, that I last saw the deceased alive on Feb. 7th, 1959, and that death occurred at 8 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Phillip J. Hirshman M.D. — ADDRESS (Street, city or town, state): 159 W. Washington St. — DATE SIGNED: 3/1/59

PHYSICIAN'S NAME (Type): Phillip J. Hirshman — Hagerstown Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 3-3-59

22c. NAME OF CEMETERY OR CREMATORY: Rest Haven Cemetery

22d. LOCATION (City, town, or county) (State): Hagerstown Md.

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Scott F. Minnich & Son Hagerstown Md.

24a. REC'D BY REGISTRAR: DATE MAR 4 '59

24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3609

CERTIFICATE OF DEATH

0361i

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 2 Days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Washington County Hospital

2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Rural Big Pool Md.
d. STREET ADDRESS: Big Pool Md.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Elby — Middle LeRoy — Last Heiston

4. DATE OF DEATH: Month 3 — Day 21 — Year 1959

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 3.9.1882

9. AGE (In years last birthday): 77 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Labor

10b. KIND OF BUSINESS OR INDUSTRY: Rail Road W.M.

11. BIRTHPLACE (State or foreign country): Elkton Va.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Samuel Heiston

14. MOTHER'S MAIDEN NAME: Betty Kite

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO: 220-16-2421

17. INFORMANT: Elsie H Heiston Address: Big Pool Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PNEUMONIA OF THE RIGHT LOWER LUNG — INTERVAL BETWEEN ONSET AND DEATH: 3 DAYS

DUE TO (b) ARTERIOSCLEROTIC CARDIOVASCULAR RENAL DISEASE — UNKNOWN

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): PARALYTIC ILEUS

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from MARCH 18, 19 59, to MARCH 21, 19 59, that I last saw the deceased alive on MARCH 20, 1959, 19, and that death occurred at 1-10 A.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: Archie Robert Cohen M D

ADDRESS (Street, city or town, state) DATE SIGNED

PHYSICIAN'S NAME (Type): ARCHIE ROBERTCOHEN, M.D. — CLEAR SPRING, MARYLAND — MARCH 21, 1959

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 3.23.59

22c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery

22d. LOCATION (City, town, or county) (State): Hagerstown Washington Md.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Howard F Hose Hancock md

24a. REC'D BY REGISTRAR DATE: MAR 26 '59

24b. REGISTRAR'S SIGNATURE: Cathan S. Haas

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3610

CERTIFICATE OF DEATH

03612

Reg. Dist. No. 302

1 PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 2½ Yrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 835 Chestnut St

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland — b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
d. STREET ADDRESS: 835 Chestnut St
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒X

3. NAME OF DECEASED (Type or print): First ROY — Middle CLINTON — Last HELFERSTAY
4. DATE OF DEATH: Month March — Day 5 — Year 1959
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒X DIVORCED ☐
8. DATE OF BIRTH: Mar 25 1884
9. AGE (In years last birthday): 74 yrs — IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours — Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Maintenance Fairchild
10b. KIND OF BUSINESS OR INDUSTRY: Retired
11. BIRTHPLACE (State or foreign country): Hagerstown Wash Co Md.
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: William Helferstay
14. MOTHER'S MAIDEN NAME: Mary Gatrell
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No — (If yes, give war or dates of service): ——
16. SOCIAL SECURITY NO: 215-14-1536
17. INFORMANT: Evelyn Hendricks — Address: 835 Chestnut St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cerebral Vascular Accident Hagerstown Md. — INTERVAL BETWEEN ONSET AND DEATH: minutes
DUE TO (b): Arteriosclerosis Gen.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour o m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 3/3/59, 19—, to 3/5/59, 19—, that I last saw the deceased alive on 3/2/59, 19—, and that death occurred at —M. from the causes and on the date stated above.

ACTUAL SIGNATURE: Louis G. Grafman M.D. — ADDRESS (Street, city or town, state): 197 E. Antrim Ave. — DATE SIGNED: 3/6/59

PHYSICIAN'S NAME (Type): Louis G. Grafman Hagerstown Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 3/9/59
22c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery
22d. LOCATION (City, town or county) (State): Hagerstown Wash. Co Md.

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Andrew K. Coffman Hagerstown Md.
24a. REC'D BY REGISTRAR — DATE: MAR 11 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Krause

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3666

CERTIFICATE OF DEATH

Reg. Dist. No. 03613

1 PLACE OF DEATH
a. COUNTY Washington — MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Williamsport
c. LENGTH OF STAY IN 1b 35 yrs.
d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 27 E. Salisbury Street

2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a STATE Maryland — b. COUNTY Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Williamsport
d STREET ADDRESS 27 E. Salisbury Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First Raymond — Middle George — Last Henesy

4. DATE OF DEATH: Month March — Day 18 — Year 1959

5. SEX: Male

6. COLOR OR RACE: White

7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Jan. 21 1910

9. AGE (In years last birthday) 49 yrs.

IF UNDER 1 YEAR: Months 1 — Days 24 — IF UNDER 24 HRS: Hours — Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Labor

10b KIND OF BUSINESS OR INDUSTRY: Tannery

11 BIRTHPLACE (State or foreign country): Washington Co. Md.

12 CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME: John Leroy Henesy

14. MOTHER'S MAIDEN NAME: Daisy Palmer

15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No — (If yes, give war or dates of service) No

16 SOCIAL SECURITY NO 215 09 7419

17 INFORMANT: Mrs. Florence Henesy — Address: 27 E. Salisbury St. Williamsport Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a) Coronary Thrombosis
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b)
DUE TO
(c)

INTERVAL BETWEEN ONSET AND DEATH: Days

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c TIME OF INJURY Month, Day, Year, Hour o m / p m — 19

20d INJURY OCCURRED While at work ☐ Not while at work ☐

20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that I attended the deceased from 3/7/59, 19__ to 3/18/59, 19__, that I last saw the deceased alive on 3/18/59, 19__, and that death occurred at 9:45 A. M. from the causes and on the date stated above.

ACTUAL SIGNATURE Carl Young M.D. — ADDRESS (Street, city or town, state) William St. Williamsport Md. — DATE SIGNED 3/19/59

PHYSICIAN'S NAME (Type)

22a BURIAL, CREMATION, REMOVAL (Specify) Burial

22b. DATE THEREOF March 21-59

22c. NAME OF CEMETERY OR CREMATORY Greenlawn Cemetery

22d. LOCATION (City, town, or county) Williamsport Md. (State)

23 FUNERAL DIRECTOR'S SIGNATURE Eddie L. Seal — ADDRESS Hagerstown Williamsport Md

24a. REC'D BY REGISTRAR DATE MAR 20 '59

24b. REGISTRAR'S SIGNATURE Arthur L. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3611 CERTIFICATE OF DEATH

Reg. Dist. No. 03614

1. PLACE OF DEATH
a. COUNTY Washington MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown, Md.
c. LENGTH OF STAY IN 1b 50yrs
d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 343 Blooms Court

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown, Maryland
d. STREET ADDRESS 1 343 Blooms Court
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First George Middle Clarence Last Hill
4. DATE OF DEATH Month May Day 30 Year 19 59
5 SEX Male
6. COLOR OR RACE Colored
7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH Mar 5 1901
9. AGE (In years last birthday) 58 yrs.
IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer
10b. KIND OF BUSINESS OR INDUSTRY Building const.
11. BIRTHPLACE (State or foreign country) Roanke Va.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Emanuel Hill
14 MOTHER'S MAIDEN NAME Ida Davis

15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no or unknown) no (If yes, give war or dates of service)
16 SOCIAL SECURITY NO 219-05-2248
17. INFORMANT Marie Kenney Address 63 Blooms Alley

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) Hypertension arteriosclerotic C V. D. — INTERVAL BETWEEN ONSET AND DEATH several yrs
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Hour a. m. p. m. Month Day Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 12/7/55, 19____, to 3/30/59, 19____, that I last saw the deceased alive on 12/16/58, 19____, and that death occurred at 10?. M, from the causes and on the date stated above.

ACTUAL SIGNATURE John M Wisch M.D. ADDRESS (Street, city or town, state) 136 North Potomac St. DATE SIGNED 4/1/59

PHYSICIAN'S NAME (Type) [illegible] Hagerstown, Maryland

22a BURIAL, CREMATION, REMOVAL (Specify) Removal
22b. DATE THEREOF 4-3-1959
22c. NAME OF CEMETERY OR CREMATORY Anatomy Board of Md.
22d LOCATION (City, town, or county) (State) Baltimore Maryland

23 FUNERAL DIRECTOR'S SIGNATURE John R Watson Jr. ADDRESS Hagerstown Md
24a. REC'D BY REGISTRAR DATE APR 3 '59
24b REGISTRAR'S SIGNATURE Arthur L. Frank

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3612 CERTIFICATE OF DEATH

Reg. Dist. No. 03615

1. PLACE OF DEATH
a. COUNTY: WASHINGTON — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAGERSTOWN
c. LENGTH OF STAY IN 1b: 11 Mo.
d. NAME OF HOSP.TAL (If not in hospital, give street address) OR INSTITUTION: WESTERN MD. STATE HOSPITAL
d. STREET ADDRESS: —
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission)
a. STATE: MD. — b. COUNTY: CALVERT
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SOLOMONS

3. NAME OF DECEASED (Type or print): First MAZIE — Middle MARIE — Last HILL

4. DATE OF DEATH: Month MARCH — Day 14 — Year 1959

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: JUNE 13, 1909

9. AGE (In years last birthday): 49 yrs

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE

10b. KIND OF BUSINESS OR INDUSTRY: HOME

11. BIRTHPLACE (State or foreign country): SOLOMONS, MD.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: JAMES R. LANGLEY

14. MOTHER'S MAIDEN NAME: MAUD M. THOMPSON

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: 220-16-9003

17. INFORMANT: ALFRED HILL — Address: SOLOMONS, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): CONFLUENT LOBULAR PNEUMONIA — INTERVAL BETWEEN ONSET AND DEATH: 3 DAYS

DUE TO (b): RIGHT TEMPORAL LOBE ABSCESS — UNKNOWN

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c): CHROMOPHOBE ADENOMA OF PITUITARY GLAND — 5 YEARS

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): PEPTIC ULCER

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour o. m. p. m., 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from APRIL 17, 1958, to MARCH 14, 1959, that I last saw the deceased alive on MARCH 14, 1959, and that death occurred at 9:35 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: George Berci M.D. — ADDRESS (Street, city or town, state): 1500 PENNSYLVANIA AVE. HAGERSTOWN, MARYLAND — DATE SIGNED: 3/15/59

PHYSICIAN'S NAME (Type): DR. GEORGE BERCI

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: MAR. 18, 1959

22c. NAME OF CEMETERY OR CREMATORY: SOLOMONS CATHOLIC CEM.

22d. LOCATION (City, town, or county) (State): SOLOMONS - CALVERT - MD.

23. FUNERAL DIRECTOR'S SIGNATURE: A. A. HARKNESS & SON — ADDRESS: MUTUAL, MD.

24a. REC'D BY REGISTRAR DATE: MAR 18 '59

24b. REGISTRAR'S SIGNATURE: Arthur S. Friend

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) and the remainder should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3613 **CERTIFICATE OF DEATH** Reg. Dist. No. 03616

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH — a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 6 months
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Washington County Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) — a. STATE: Maryland — b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Samples Manor
d. STREET ADDRESS: Harpers Ferry Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First MINNIE — Middle BELLE — Last HOFFMASTER
4. DATE OF DEATH: Month MARCH — Day 12, — Year 1959

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: June 2, 1874
9. AGE (In years last birthday): 84 yrs
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Antietam Furnace, Md.
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Eli Hamilton Eichelberger
14. MOTHER'S MAIDEN NAME: Annie Virginia Roulette

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): None
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Mrs. Thuryle Taylor
216 N. Cannon Ave., Hagerstown, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) [illegible] — INTERVAL BETWEEN ONSET AND DEATH
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) [illegible]
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Hour a. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that I attended the deceased from [illegible], 19[illegible], to [illegible], 19[illegible], that I last saw the deceased alive on [illegible], 19[illegible], and that death occurred at 1:15A M, from the causes and on the date stated above.

ACTUAL SIGNATURE [signature] M.D. — ADDRESS (Street, city or town, state): N.Potomac St., Hagerstown, Md. — DATE SIGNED: 3/13/59

PHYSICIAN NAME (Type): J. D. Wilson, M.D. — N.Potomac St., Hagerstown, Md. — 3/13/59

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 3/14/59
22c. NAME OF CEMETERY OR CREMATORY: Samples Manor Cemetery
22d. LOCATION (City, town, or county) (State): Samples Manor, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: H. Donald Zeckler — ADDRESS: Harpers Ferry West Va.
24a. REC'D BY REGISTRAR DATE: MAR 17 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Kinna

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03617

Reg. Dist. No. 3614

FOR STATE HEALTH DEPT.

1. PLACE OF DEATH — a COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 8 hours
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): In Cell at City Police Headquarters

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) — a STATE: PENNA. — b COUNTY: ALLEGHANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): McKEESPORT
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Vincent — Middle: (None) — Last: Honick
4. DATE OF DEATH: Month: Mar. — Day: 7 — Year: 1959

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒
8. DATE OF BIRTH: MARCH 1914
9. AGE (In years last birthday): 44 yrs
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): NONE
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): PENNA.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: MICHAEL HONICK
14. MOTHER'S MAIDEN NAME: UNKNOWN

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: NONE
17. INFORMANT — Address: GEORGE HONICK McKEESPORT, PA.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Asphyxia due to hanging
174X
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):
INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18): Hanged self in cell at Police Headquarters with his belt
20c. TIME OF INJURY: Hour: 1:00 xxx — Month, Day, Year: Mar 7 1959
20d. INJURY OCCURRED: While at work ☐ Not while at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Cell
20f. (City or town) (County) (State): Hagerstown Wash Md

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☒, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: S. Robert Wells M.D.
EXAMINER'S NAME (Type): S. Robert Wells, M.D.
CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 3-9-59

22a. BURIAL CREMATION REMOVAL (Specify): BURIAL
22b. DATE THEREOF: MARCH 11, 1959
22c. NAME OF CEMETERY OR CREMATORY: FAIRVIEW CEMETERY
22d. LOCATION (City, town, or county) (State): McKEESPORT PA.

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: CHECK FUNERAL HOME McKEESPORT, PA.
24a. REC'D BY REGISTRAR — DATE: MAR 10 '59
24b. REGISTRAR'S SIGNATURE: Curtiss L. Kraus

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal. Page 3 in any shipment within (export) after death.

VS. A15ME
BM 2 57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3615

CERTIFICATE OF DEATH

03615

Reg. Dist. No.

1 PLACE OF DEATH
a COUNTY [illegible] MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN
c LENGTH OF STAY IN 1b 7 MONTHS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION [illegible]

2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission)
a. STATE [illegible] b. COUNTY [illegible]
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 HAGERSTOWN
d STREET ADDRESS [illegible]
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3 NAME OF DECEASED (Type or print) First ORA Middle ALBERTA Last HORTON

4. DATE OF DEATH Month March Day 7 Year 1959

5 SEX [illegible]
6. COLOR OR RACE [illegible]
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8 DATE OF BIRTH [illegible]
9. AGE (In years last birthday) [illegible] yrs
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS Hours Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE
10b. KIND OF BUSINESS OR INDUSTRY
11 BIRTHPLACE (State or foreign country) [illegible]
12 CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME [illegible]
14 MOTHER'S MAIDEN NAME [illegible]

15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. ——
17 INFORMANT Address MRS. ELTA HORTON HAGERSTOWN, MD

MEDICAL CERTIFICATION

18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Confluent lobular pneumonia, bilateral — INTERVAL BETWEEN ONSET AND DEATH 3 days

DUE TO (b) carcinoma of vulva & metastasis to inguinal + pelvic lymph nodes — 14 months

DUE TO (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 176.0

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) carcinoma of endometrium

19 WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that I attended the deceased from Aug. 28, 1958, to March 7, 1959, that I last saw the deceased alive on March 7, 1959, and that death occurred at 8:10 P.M., from the causes and on the date stated above

ACTUAL SIGNATURE Victor L. Ramos M.D. ADDRESS (Street, city or town, state) Western Maryland State Hospital Manley DATE SIGNED

PHYSICIAN'S NAME (Type) VICTOR L. RAMOS Hagerstown, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify) [illegible]
22b. DATE THEREOF [illegible]
22c NAME OF CEMETERY OR CREMATORY BROAD TOP CEMETERY
22d. LOCATION (City, town, or county) [illegible] (State)

23 FUNERAL DIRECTOR'S SIGNATURE [illegible] ADDRESS [illegible] MD.

24a. REC'D BY REGISTRAR DATE MAR 11 '59
24b REGISTRAR'S SIGNATURE Arthur L. Kuns

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
IBM 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03619

3667

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Williamsport Md RFD#1
c. LENGTH OF STAY IN 1b: 35 yrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Pinesburg

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Williamsport Md. RFD. # 1
d. STREET ADDRESS: Pinesburg
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Matilda — Middle: Lamona — Last: Hose

4. DATE OF DEATH: Month: March — Day: 29 — Year: 1959

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Aug. 31 1890

9. AGE (In years last birthday): 68 yrs.
IF UNDER 1 YEAR: Months: 6 — Days: 25
IF UNDER 24 HRS: Hours: — Min:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY: U.S.A

13. FATHER'S NAME: George Dickerhoff

14. MOTHER'S MAIDEN NAME: Betty (Unknown)

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service): No

16. SOCIAL SECURITY NO: None

17. INFORMANT: Mr. George Hose — Address: Pinesburg Williamsport Md RFD 1

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinoma of Lung Primary — INTERVAL BETWEEN ONSET AND DEATH: 1 Day
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c): 420.1

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month Day Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 3/24/59 19 to 3/29/59 19, that I last saw the deceased alive on 3/29/59 19, and that death occurred at 4:30 p.m. from the causes and on the date stated above.

ACTUAL SIGNATURE: Ralph F Ypung M.D. — ADDRESS (Street, city or town, state): Williamsport, Md — DATE SIGNED: 3/30/59

PHYSICIAN'S NAME (Type): Ralph F. Ypung M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: March 31-59
22c. NAME OF CEMETERY OR CREMATORY: Greenlawn Cemetery
22d. LOCATION (City, town, or county) (State): Williamsport Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Albert Leaf — ADDRESS: Williamsport, Md

24a. RECD BY REGISTRAR DATE: APR 1 '59

24b. REGISTRAR'S SIGNATURE: Conrad L. Mauk

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3616 item 14 filed 3-11-59 at

CERTIFICATE OF DEATH

03620

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 51 years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Washington County Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
d. STREET ADDRESS: 230 Alexander St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Mary — Middle: Jane — Last: Hovermill

4. DATE OF DEATH: Month: March — Day: 6 — Year: 1959

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Jan. 16, 1882
9. AGE (In years last birthday): 77 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Sleepy Creek W. Va.
12 CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: John Laign
14. MOTHER'S MAIDEN NAME: Mary I. Riser

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): —
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: —
17. INFORMANT: William F. Hovermill — Address: Hagerstown Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: 18 hrs
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Gen'l arteriosclerosis and arteriosc. — 10 yrs
DUE TO
(c): cardiac heart disease

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Chronic chole cystitis
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a. m. p. m. / Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from May 11, 1958 to Mar 6, 1959, that I last saw the deceased alive on Mar 6, 1959, and that death occurred at 4:45 P.M., from the causes and on the date stated above

ACTUAL SIGNATURE: Edward W. Ditto III M.D.
ADDRESS (Street, city or town, state): 217 W. Washington St.
DATE SIGNED:
PHYSICIAN'S NAME (Type): Edward W. Ditto III — Hagerstown Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 3-8-59
22c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery
22d. LOCATION (City, town, or county) (State): Hagerstown Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Scott F. Minnich & Son — ADDRESS: Hagerstown Md.
24a. REC'D BY REGISTRAR DATE: MAR 9 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

3668 — 03621 — Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: WASHINGTON — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL
c. LENGTH OF STAY IN 1b: 19 MONTHS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: HAGERSTOWN MD. R.1

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: WASHINGTON
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL
d. STREET ADDRESS: HAGERSTOWN MD. R.1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) — First: BERTHA — Middle: NAOMI — Last: HUNTZBERRY

4. DATE OF DEATH — Month: MARCH — Day: 27 — Year: 1959

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: AUG. 22-1882

9. AGE (In years last birthday): 76 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSE WIFE

10b. KIND OF BUSINESS OR INDUSTRY: OWN HOME

11. BIRTHPLACE (State or foreign country): TILGHMANTON WASH. Co

12. CITIZEN OF WHAT COUNTRY? MD U.S.A.

13. FATHER'S NAME: FRISBY SHOWE

14. MOTHER'S MAIDEN NAME: ANNA JACOBS

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): NO

16. SOCIAL SECURITY NO.: NONE

17. INFORMANT: MRS. HARRY S. PALMER — Address: HAGERSTOWN MD. R.1

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Art[illegible]sclerotic Cardiov[illegible] [illegible] — INTERVAL BETWEEN ONSET AND DEATH: [illegible]
4 d d.1
DUE TO (b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
DUE TO (c)

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year 19 — Hour a. m. p. m.

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I **certify** that I attended the deceased from 10-19-, 1957, to [illegible], 19[illegible], that I last saw the deceased alive on 3-14-[illegible], 19, and that death occurred at 7:[illegible]P M, from the causes and on the date stated above

ACTUAL SIGNATURE: [signature] M D — ADDRESS (Street, city or town, state): S[illegible] — DATE SIGNED: [illegible]

PHYSICIAN'S NAME (Type): Charles [illegible]

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: MARCH. 31. 1959

22c. NAME OF CEMETERY OR CREMATORY: SMITHSBURG CEMETERY

22d. LOCATION (City, town, or county) (State): SMITHSBURG WASH. CO MD.

23. FUNERAL DIRECTOR'S SIGNATURE: John H. Bast — ADDRESS: Boonsboro Md.

24a. REC'D BY REGISTRAR DATE MAR 31 '59

24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3617

CERTIFICATE OF DEATH

Reg. Dist. No. 03623

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 8yrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Carlock Nursing Home

2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Penna — b. COUNTY: Franklin
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Greencastle
d. STREET ADDRESS: E. Franklin st.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Elizabeth — Middle: Frances — Last: Hussong

4. DATE OF DEATH: Month: March — Day: 28, — Year: 1959

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: July 24, 1866

9. AGE (In years last birthday): 92 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife

10b. KIND OF BUSINESS OR INDUSTRY: Housekeeping

11. BIRTHPLACE (State or foreign country): Greencastle Franklin Co. Pa

12. CITIZEN OF WHAT COUNTRY? USA.

13 FATHER'S NAME: Emanuel Lenhart

14. MOTHER'S MAIDEN NAME: Rebecca Warner

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Address: Mr. Harold Lehman, Waynesboro, Pa

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Medulla Oblongata Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 6½ hrs.

4435

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Hypertensive Cardiovascular Disease — 20 yrs.

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1945, 19, to 3/28, 59 that I last saw the deceased alive on 3/28/59, 19, and that death occurred at 11:45 P.M., from the causes and on the date stated above

ADDRESS (Street, city or town, state) DATE SIGNED

ACTUAL SIGNATURE: W. C. Brewer M.D. — 359 E. Baltimore St., Greencastle, Pa. 3/30/59

PHYSICIAN'S NAME (Type): W. C. Brewer, M.D.

22a BURIAL, CREMATION, REMOVAL (Specify): Burial

22b DATE THEREOF: 3/31/1959

22c NAME OF CEMETERY OR CREMATORY: Cedar Hill Cemetery

22d LOCATION (City, town, or county) (State): Greencastle Franklin Co. Pa

23 FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: Harold M. Zimmerman, Greencastle, Pa

24a REC'D BY REGISTRAR DATE: MAR 31 59

24b REGISTRAR'S SIGNATURE: Grover C. Fritz

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

3618

Reg. Dist. No. 03623

1. PLACE OF DEATH
a. COUNTY Washington MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown
c. LENGTH OF STAY IN 1b 16 years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
a. STATE Maryland b. COUNTY Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown
d. STREET ADDRESS 117 Fairground Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First Laura Middle Virginia Last Itneyer

4. DATE OF DEATH Month March Day 20 Year 1959

5. SEX Female
6. COLOR OR RACE White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH Nov. 5, 1881
9. AGE (In years last birthday) 77 yrs.
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife
10b. KIND OF BUSINESS OR INDUSTRY Own Home
11. BIRTHPLACE (State or foreign country) Near Chewsville Md.
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME Abner Neff
14. MOTHER'S MAIDEN NAME Salome Stockslager

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Address Miss Erma Itneyer Hagerstown Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Cerebral thrombosis — INTERVAL BETWEEN ONSET AND DEATH 53 days
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Arteriosclerotic myocardial heart disease with myocardial failure
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. None Month, Day, Year 19
20d. INJURY OCCURRED White at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Oct. 19 50, to March 20 19 59, that I last saw the deceased alive on March 20 19 59, and that death occurred at 4:05 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE S. Robert Wells M.D.
ADDRESS (Street, city or town, state) 115 N. Potomac St.
DATE SIGNED 3-21-59

PHYSICIAN'S NAME (Type) S. Robert Wells Hagerstown Md.

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 3-23-59
22c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery
22d. LOCATION (City, town, or county) (State) Hagerstown Md.

23. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son
ADDRESS Hagerstownm Md.
24a. REC'D BY REGISTRAR DATE MAR 24 '59
24b. REGISTRAR'S SIGNATURE Arthur S. Hawes

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers—Pages 1 and the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3619

CERTIFICATE OF DEATH

Reg. Dist. No. 03624

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/55

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown, Maryland
c. LENGTH OF STAY IN 1b: 35yrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 112 Bloom Ave.

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown, Hagerstown.
d. STREET ADDRESS: 112 Bloom Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Theodosia — Middle: Caleetiee — Last: Jones

4. DATE OF DEATH: Month: March — Day: 17 — Year: 1959

5. SEX: Female

6. COLOR OR RACE: Colored

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Mar 8 1907

9. AGE (In years last birthday): 52 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Domestic

10b. KIND OF BUSINESS OR INDUSTRY: Own home

11. BIRTHPLACE (State or foreign country): Burkettsville, Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Thomas Dorsey

14. MOTHER'S MAIDEN NAME: Mary Boyce

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: none

17. INFORMANT: John Jones — Address: 112 Bloom Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Rheumatic Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: 10 yrs.

416X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — 20f (City or town) (County) (State)

21. I certify that I attended the deceased from Nov. 19 59 to March 17 19 59 that I last saw the deceased alive on March 16 19 59, and that death occurred at 7:30 M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Philip J. Hirshman M.D. — ADDRESS (Street, city or town, state): 159 W. Washington St., — DATE SIGNED: 3/20/59

PHYSICIAN'S NAME (Type): Philip J. Hirshman, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 3-21-1959

22c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery

22d. LOCATION (City, town or county) (State): Hagerstown Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: John R Watson Jr — ADDRESS: Hagerstown Md

24a. REC'D BY REGISTRAR — DATE: MAR 23 '59

24b. REGISTRAR'S SIGNATURE: Clifton L. Keane

1

FOR STATE HEALTH DEPT.

M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03625

3620 Reg. Dist. No.

1 PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): D.O.A.- Emergency Room- Hospital

2 USUAL RESIDENCE (Where deceased lived. If inst'l pt'n, Residence before admission)
a. STATE: Maryland — b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Hancock
d. STREET ADDRESS: R # 1
e. IS RESIDENCE ON A FARM: YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Anna — Middle Margaret — Last Kellner
4. DATE OF DEATH: Month March — Day 2 — Year 19 59
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: April 6, 1897
9. AGE (In years last birthday): 61 yrs
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Lady Companion
10b. KIND OF BUSINESS OR INDUSTRY: Elderly Lady
11. BIRTHPLACE (State or foreign country): Fulton County, Pa.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Adam Kellner
14. MOTHER'S MAIDEN NAME: Emma Trauz

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO: None
17. INFORMANT: Mrs. Mary Hixon Hancock, (Sister) — Address Md

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Fractured Skull; Hemorrhage and shock — INTERVAL BETWEEN ONSET AND DEATH
812 X
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): None
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.): Pedestrian that was struck by automobile while crossing street
20c. TIME OF INJURY: Hour XXX 6:45 p.m. — Month, Day, Year Mar. 2 1959
20d. INJURY OCCURRED: While at work ☐ Not while at work ☒
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Street
20f. (City or town) Hagerstown (County) Wash (State) Md

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: S Robert Wells M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 3-3-59
EXAMINER'S NAME (Type): S, Robert Wells, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 3-5-59
22c NAME OF CEMETERY OR CREMATORY: Antioch Christian
22d. LOCATION (City, town, or county) Timber Ridge (Thompson) (State) Pa

23 FUNERAL DIRECTOR'S SIGNATURE: Howard F Gore — ADDRESS: Hancock Md
24a. REC'D BY REGISTRAR DATE: MAR 9 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Kuhns

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
BM 2. 57

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3621

CERTIFICATE OF DEATH

Reg. Dist. No. 03626

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown, Md.
c. LENGTH OF STAY IN 1b: Life time
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Washington County Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown, Maryland
d. STREET ADDRESS: 122 W. Bethel Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: George — Middle: Hillary — Last: Keyes

4. DATE OF DEATH: Month: March — Day: 7 — Year: 1959

5. SEX: Male

6. COLOR OR RACE: Colored

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: June 10 1904

9. AGE (In years last b'rthday): 54 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Bartender

10b. KIND OF BUSINESS OR INDUSTRY: Fraternal Club

11. BIRTHPLACE (State or foreign country): Hagerstown Maryland

12. CITIZEN OF WHAT COUNTRY? USA.

13. FATHER'S NAME: George Keyes

14. MOTHER'S MAIDEN NAME: Florence Jackson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO: 215-20-9949

17. INFORMANT: Miss Lillian Keyes — Address: 314½ N. Jonathan St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 2 days

DUE TO (b): Generalized Arteriosclerosis — 4 yrs

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c):

332 X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Acute Alcoholism — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour: a. m. / p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — 20f (City or town) (County) (State)

21. I certify that I attended the deceased from Jan. 19 59 to March 7 19 59 that I last saw the deceased alive on March 7 19 59, and that death occurred at 10:30 A. M., from the causes and on the date stated above.

ACTUAL SIGNATURE: [signature] M.D. — ADDRESS (Street, city or town, state): Hagerstown Md — DATE SIGNED: March 9/59

PHYSICIAN'S NAME (Type): [illegible]

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 3-11-1959

22c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery

22d. LOCATION (City, town, or county) (State): Hagerstown, Maryland.

23. FUNERAL DIRECTOR'S SIGNATURE: John P. Watson Jr. — ADDRESS: Hagerstown Md

24a. REC'D BY REGISTRAR — DATE: MAR 13 '59

24b. REGISTRAR'S SIGNATURE: Arthur S. Kreps

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3622 CERTIFICATE OF DEATH

03627
Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 1 Year
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Garlock Nursing Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Md. — b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Ringgold Md.
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Ada — Middle: Lenora — Last: King

4. DATE OF DEATH: Month: March — Day: 10 — Year: 19 59

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 8/26/1877

9. AGE (In years last birthday): 81 yrs
IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Washington Co., Md.

12 CITIZEN OF WHAT COUNTRY? U.S.A.

13 FATHER'S NAME: William Hause

14 MOTHER'S MAIDEN NAME: Lizzie M. Beard

15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):

16. SOCIAL SECURITY NO:

17 INFORMANT: Mrs. Dessie Crunkleton, State Line Penna. (Address)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a): Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 1 wk

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO

(c) Generalized Arterio Sclerosis — 10 yrs

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour: o. m. / p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that I attended the deceased from 4-18-58 19___, to 3-10 19 59 that I last saw the deceased alive on 3-10 19 59, and that death occurred at 11 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: G. A. Kohler M.D. — ADDRESS (Street, city or town, state): Smithsburg Md. — DATE SIGNED: 3/10/59

PHYSICIAN'S NAME (Type): G. A. Kohler

22a BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 3/13/59

22c. NAME OF CEMETERY OR CREMATORY: Green Hill

22d LOCATION (City, town, or county) (State): Waynesboro, Franklin Pa.

23 FUNERAL DIRECTOR'S SIGNATURE: [illegible] — ADDRESS: [illegible] Grove, Waynesboro Pa

24a REC'D BY REGISTRAR DATE: MAR 12 '59

24b REGISTRAR'S SIGNATURE: [illegible]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03628

3623 **CERTIFICATE OF DEATH**

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

1. PLACE OF DEATH
a COUNTY: Washington — MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: Months
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Western Maryland State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)
a STATE: Maryland
b COUNTY: Frederick
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Frederick
d STREET ADDRESS: 126 West Patrick Street
e IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: John Middle: (Bernard) A. Last: KLINE

4. DATE OF DEATH: Month: March Day: 18 Year: 1959

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: August 5, 1929

9. AGE (In years last birthday): 29 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY: Bowling Alley

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY: USA

13. FATHER'S NAME: Arthur G. Kline, Sr.

14. MOTHER'S MAIDEN NAME: Mattie V. Grimes

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): NO
(If yes, give war or dates of service): No

16. SOCIAL SECURITY NO: 219-20-2856

17. INFORMANT: Address: 103 East Second Street
Mrs. Mattie V. Kline, Frederick, Maryland

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pulmonary Edema and Congestion — INTERVAL BETWEEN ONSET AND DEATH: 4 days
DUE TO (b): Portal Cirrhosis — 6 months
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

571.0

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Esophageal Varices, Ascites.

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c, TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from March 11, 1959 to March 17, 1959, that I last saw the deceased alive on March 17, 1959, and that death occurred at 8:05 A.M., from the causes and on the date stated above

ACTUAL SIGNATURE: Eusebio R Lardizabal M.D. ADDRESS (Street, city or town, state): 1500 Pennsylvania Ave DATE SIGNED: 3-18-59

PHYSICIAN'S NAME (Type): Eusebio R. Lardizabal Hagerstown Md.

22a BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Mar. 21, 1959

22c NAME OF CEMETERY OR CREMATORY: Mount Olivet Cemetery

22d LOCATION (City, town, or county) (State): Frederick, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: M. R. Etchison & Son, Frederick, Maryland

24a. REC'D BY REGISTRAR DATE: MAR 20 '59

24b REGISTRAR'S SIGNATURE: Arthur S. Kline

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 shall be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3624

CERTIFICATE OF DEATH

03629
Reg. Dist. No.

1 PLACE OF DEATH
a. COUNTY: Washington — MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md. b. COUNTY: Wash.

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 25 years
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Washington County Hospital
d. STREET ADDRESS: 1112 S. Potomac St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First Daniel — Middle Preston — Last Knode, Sr.
4. DATE OF DEATH: Month March — Day 2, — Year 1959

5. SEX: male
6. COLOR OR RACE: white
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: June 3, 1889
9. AGE (In years last birthday): 69 yrs
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): postal clerk
10b. KIND OF BUSINESS OR INDUSTRY: railroad
11. BIRTHPLACE (State or foreign country): Sheperdstown, W. Va.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Alfred L. Knode
14. MOTHER'S MAIDEN NAME: Lydia Cloud

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: none
17. INFORMANT: Vesta K. Knode, Address: Hagerstown, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a): Hypertensive Cardiovascular Disease. — INTERVAL BETWEEN ONSET AND DEATH: 5 days

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) Pulmonary Emphysema & Fibrosis — Years.

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Bronchial Asthma.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Feb. 25, 1959 to Mar. 2, 1959 that I last saw the deceased alive on March 1, 1959, and that death occurred at 5:15 A.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: R. A. Bell M.D. — ADDRESS (Street, city or town, state): 119 North Potomac Street, Hagerstown, Maryland. — DATE SIGNED: 3-3-59

PHYSICIAN'S NAME (Type): R.A.Bell, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): burial
22b. DATE THEREOF: 3-5-59
22c. NAME OF CEMETERY OR CREMATORY: Elmwood Cemetery
22d LOCATION (City, town, or county) (State): Shepherdstown W. Va.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Scott F. Minnich & Son, Hagerstown, Md.
24a. REC'D BY REGISTRAR DATE: MAR 4 '59
24b REGISTRAR'S SIGNATURE: Arthur L. Kruse

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

3625 — Reg. Dist. No. 03630

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1. PLACE OF DEATH
a. COUNTY: WASHINGTON — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAGERSTOWN
c. LENGTH OF STAY IN 1b: 50 YEARS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 306 N. LOCUST ST

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: WASHINGTON
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAGERSTOWN
d. STREET ADDRESS: 306 N. LOCUST ST.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First GEORGE Middle THOMAS Last LYNCH

4. DATE OF DEATH: Month MARCH Day 4 Year 1959

5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: JANUARY 21 1877
9. AGE (In years last birthday): 82 yrs.
IF UNDER 1 YEAR: Months ____ Days ____
IF UNDER 24 HRS: Hours ____ Min. ____

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED SALESMAN
10b. KIND OF BUSINESS OR INDUSTRY: HOFFMAN CHEVROLET SALES
11. BIRTHPLACE (State or foreign country): BENEVOLA WASH. Co. MD. U.S.A.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: HILLIARY LYNCH
14. MOTHER'S MAIDEN NAME: MARY O'NEAL

15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 214-09-3447
17. INFORMANT: MRS. VERNIE LYNCH — Address: 306 N. LOCUST ST HAGERSTOWN, MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Thrombosis
DUE TO (b): Arteriosclerosis
DUE TO (c): ____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
420.1
INTERVAL BETWEEN ONSET AND DEATH: Unknown / Years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Hour o m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Pronounced dead At Home 19____, that I last saw the deceased alive on ____, 19____, and that death occurred at ____M, from the causes and on the date stated above

ACTUAL SIGNATURE: Howard N. Weeks M.D.
ADDRESS (Street, city or town, state): 136 N. Potomac
DATE SIGNED: 3/4/59
PHYSICIAN'S NAME (Type): Howard N. Weeks, M.D. Hagerstown, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: MARCH 7 1959
22c. NAME OF CEMETERY OR CREMATORY: BOONSBORO CEMETERY
22d. LOCATION (City, town, or county) (State): BOONSBORO WASH Co. MD

23. FUNERAL DIRECTOR'S SIGNATURE: John H. Byrd
ADDRESS: Boonsboro Md
24a. REC'D BY REGISTRAR DATE: MAR 11 '59
24b. REGISTRAR'S SIGNATURE: Esther L. Shank

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3626

CERTIFICATE OF DEATH

Reg. Dist. No. 03631

1. PLACE OF DEATH
a. COUNTY: WASHINGTON — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAGERSTOWN
c. LENGTH OF STAY IN 1b: LIFE
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 271 S. POTOMAC ST.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: WASHINGTON
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAGERSTOWN
d. STREET ADDRESS: 271 S. POTOMAC ST.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First JAMES — Middle JOSEPH — Last MATTHEWS

4. DATE OF DEATH: Month MARCH — Day 21 — Year 19 59

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 11/18/1901

9. AGE (In years last birthday): 57 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): TOO L MAKER

10b. KIND OF BUSINESS OR INDUSTRY: AIRCRAFT CO.

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: JAMES MATTHEWS

14. MOTHER'S MAIDEN NAME: MARY McDEVITT

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): NO
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO: 214-09-7873

17. INFORMANT: MRS. MAUDE MATTHEWS — Address: HAGERSTOWN MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	1 SOX	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b)	acute coronary thrombosis	1hr.
DUE TO (c)	Diabetes M	19 yrs
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year: Hour a. m. p. m. none 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Oct. 19 40 to March 21 19 59, that I last saw the deceased alive on Dec. 22 19 58, and that death occurred at 2:15A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: S. Robert Wells M.D.
ADDRESS (Street, city or town, state): 115 N. Potomac St., Hagerstown, Md.
DATE SIGNED: Mar. 22 '59

PHYSICIAN'S NAME (Type): S. Robert Wells, M. D.

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 3/27/59
22c. NAME OF CEMETERY OR CREMATORY: ROSE HILL CEM.
22d. LOCATION (City, town, or county) (State): HAGERSTOWN MD.

23. FUNERAL DIRECTOR'S SIGNATURE: [illegible]
ADDRESS: [illegible]

24a. REC'D BY REGISTRAR DATE: MAR 24 '59
24b. REGISTRAR'S SIGNATURE: Arthur L. Frame

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

3627 — Reg. Dist. No. 03632

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 3 wks.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Washington County Hospital

2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland — b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
d. STREET ADDRESS: 1106 Virginia Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First CLARENCE — Middle ANDREW — Last McCOLLUM

4. DATE OF DEATH: Month March — Day 29 — Year 1959

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: August 6,1904

9. AGE (In years last birthday): 54 yrs.

IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Bus Mechanic

10b. KIND OF BUSINESS OR INDUSTRY: Transportation

11. BIRTHPLACE (State or foreign country): Ritchie County, W.Va.

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: J.W.McCollum

14. MOTHER'S MAIDEN NAME: Fanney Rouse

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)

16. SOCIAL SECURITY NO: 235-12-2168

17. INFORMANT: Mrs.Margaret B.McCollum — Address: Hagerstown, Md. 1106 Virginia Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a): Congestive Heart Failure due to — INTERVAL BETWEEN ONSET AND DEATH:

422.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Arteriosclerotic Cardiovascular Dis. — 3 weeks.

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): None.

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month, Day, Year — Hour a. m. p. m. — 19

20d INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — **20f.** (City or town) (County) (State)

21. I certify that I attended the deceased from March 6, 1959 to March 29, 1959 that I last saw the deceased alive on March 28, 1959, and that death occurred at 12:45 M. from the causes and on the date stated above.

ACTUAL SIGNATURE: R.A.Bell M.D. — ADDRESS (Street, city or town, state): 119 North Potomac Street, Hagerstown, Maryland. — DATE SIGNED: 3-30-59

PHYSICIAN'S NAME (Type): R.A.Bell, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial — **22b. DATE THEREOF**: April 1,1959 — **22c NAME OF CEMETERY OR CREMATORY**: Sun Set — **22d LOCATION** (City, town, or county) (State): Clay W.Va.

23. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: Rest Haven Funeral Chapel Inc. Hagerstown, Md.

24a. RECD BY REGISTRAR DATE: APR 2 '59 — **24b REGISTRAR'S SIGNATURE**: Chester L. Myers

Wm. G. Hoar C-Pres.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4) ISM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3628 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 03633

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Ha erstown
c. LENGTH OF STAY IN 1b: 10 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Western Maryland Chronic Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ~~Kensington~~ CHEVY CHASE
d. STREET ADDRESS: 3939 Newdale Road — e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Sarah — Middle: Jane — Last: Mead
4. DATE OF DEATH: Month: March — Day: 19 — Year: 1959

5. SEX: FeMale
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 11-8-15
9. AGE (In years last birthday): 43 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): SALESLADY
10b. KIND OF BUSINESS OR INDUSTRY: BEST & CO.
11. BIRTHPLACE (State or foreign country): GEORGIA
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: JAMES WESLEY MEAD
14. MOTHER'S MAIDEN NAME: ADA JOY

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service): no
16. SOCIAL SECURITY NO.: 577-05-9605
17. INFORMANT — Address: Mr. Kenneth P. Mead, 2706 Terripin Rd. Silver Spring, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Gun shot wound thru skull and brain — INTERVAL BETWEEN ONSET AND DEATH: 6 mos
DUE TO (b): Carcinomatosis of peritoneum
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c): Bilateral bronchial pneumonia

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. [Enter nature of injury in Part I or Part II of item 18.]: Shot self thru skull with 38 revolver
20c. TIME OF INJURY — Hour: 2:30 p. m. — Month, Day, Year: Sept 12 19 58
20d. INJURY OCCURRED — While at work ☐ Not while at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): at home
20f. (City or town): Kensington — (County): Montgomery — (State): Md

21. I certify that I taak charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☐, Suicide ☒, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: S. Robert Wells M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 3-20-59
EXAMINER'S NAME (Type): S. Robert Wells, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 3/23/59
22c. NAME OF CEMETERY OR CREMATORY: BURTONSVILLE UNION CEMETERY
22d. LOCATION (City, town, or county) (State): MONTGOMERY COUNTY, MD.

23. FUNERAL DIRECTOR'S SIGNATURE: [illegible] PUMPHREY, INC. Raymond A Liska
ADDRESS: SILVER SPRING, MD.
24a. REC'D BY REGISTRAR — DATE: MAR 23 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Kruse

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within ■ hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file. Page 4 should be TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03634

3629

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH
a. COUNTY: Washinton — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: 2075 Greenfield Road

2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
d. STREET ADDRESS: 2075 Greenfield Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First KATHERINE — Middle FENTON — Last MILLER

4. DATE OF DEATH: Month March — Day 12 — Year 19 59

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: July 5, 1871

9. AGE (In years last birthday): 87 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Quincy, Illinois

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William W. Fenton

14. MOTHER'S MAIDEN NAME: Catherine Guthrie

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO: none

17. INFORMANT: Elizabeth I. Miller — Address: Hagerstown, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arterio sclerotic Heart Disease with
DUE TO (b): febrillation + myocardial failure
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: 2yrs +

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Hour a. m. p. m. Month Day Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from March, 19 57, to Mar 12, 19 59, that I last saw the deceased alive on 10 Mar, 19 59, and that death occurred at 9 00 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: F F Lusby M.D.
ADDRESS (Street, city or town, state): 230 N Potomac St Hagerstown Md
DATE SIGNED: 12 Mar 59

PHYSICIAN'S NAME (Type): F. F. Lusby

22a. BURIAL, CREMATION, REMOVAL (Specify): Removal

22b. DATE THEREOF: 3/12/1959

22c. NAME OF CEMETERY OR CREMATORY: Alliance Cemetery

22d. LOCATION (City, town, or county): Alliance (State): Ohio

23. FUNERAL DIRECTOR'S SIGNATURE: Suter-Rouzer Funeral Home
ADDRESS: Hagerstown, Md.

24a. REC'D BY REGISTRAR DATE: MAR 16 '59

24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 10/57

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be recorded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
BM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03635

3669 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Pectonville
c. LENGTH OF STAY IN 1b: Life
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): at home

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland — b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Pectonville
d. STREET ADDRESS: Big Pool Md.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Garrett — Middle: Clymar — Last: Mills
4. DATE OF DEATH: Month: March — Day: 2 — Year: 1959
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Dec. 1, 1894
9. AGE (In years last birthday): 64 yrs — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Operator-Grocery Store
10b. KIND OF BUSINESS OR INDUSTRY: Grocery
11. BIRTHPLACE (State or foreign country): Wash. Co.
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Alvery Mills
14. MOTHER'S MAIDEN NAME: Emma Myers
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO: 217-10-9526
17. INFORMANT (Address): Mrs. Sally E. S. Mills - Pectonville, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Acute & chronic coronary thrombosis
DUE TO (b): Arteriosclerotic coronary heart disease
DUE TO (c): Hypertensive myocardial vascular disease
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18): none
20c. TIME OF INJURY: Hour: o. m / p. m — Month, Day, Year: none 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): none
20f. (City or town) — (County) — (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒ Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: S. Robert Wells M.D.
EXAMINER'S NAME (Type): S. Robert Wells, M.D,
CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: March 2 '59

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 3-4-59
22c. NAME OF CEMETERY OR CREMATORY: Park Lead Cemetery
22d. LOCATION (City, town, or county) (State): Park Lead Wash Md

23. FUNERAL DIRECTOR'S SIGNATURE: Howard F. Gore
ADDRESS: Hancock Md
24c. REC'D BY REGISTRAR DATE: MAR 9 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3630 **CERTIFICATE OF DEATH** Reg. Dist. No. 03636

1. PLACE OF DEATH
a. COUNTY: WASHINGTON — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAGERSTOWN
c. LENGTH OF STAY IN 1b: FIVE MONTHS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: WESTERN MARYLAND STATE HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: FREDERICK
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL 10K
d STREET ADDRESS: MYERSVILLE MD. ROUTE 2
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First EVA — Middle IRENE — Last MORTS
4. DATE OF DEATH: Month MARCH — Day 6 — Year 1959

5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH: JULY-15-1906
9. AGE (In years last birthday): 52 yrs.
IF UNDER 1 YEAR: Months — Days; IF UNDER 24 HRS: Hours — Min.

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSE WIFE
10b. KIND OF BUSINESS OR INDUSTRY: OWN HOME
11. BIRTHPLACE (State or foreign country): MYERSVILLE FRED. CO. MD. U.S.A.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: ELMER PALMER
14. MOTHER'S MAIDEN NAME: JANE MASER

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service)
16 SOCIAL SECURITY NO: NONE
17. INFORMANT: JOHN F. MORTS — Address: MYERSVILLE FRED. CO. MD. R.2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Embolus, left lower Lobe left lung — INTERVAL BETWEEN ONSET AND DEATH: 3 DAYS
153.3
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b) RECURRENT CARCINOMATOSIS — Sigmoid — 5 YEARS
DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES [X] NO [ ]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work [ ] Not while at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Oct 10 1958, to March 6 1959, that I last saw the deceased alive on March 5 1959, and that death occurred at 3:30 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Eduardo R. Lardizabal M.D. — ADDRESS (Street, city or town, state): 1502 Pennsylvania Ave — DATE SIGNED

PHYSICIAN'S NAME (Type): Eduardo R. Lardizabal — Hagerstown, Md.

22a BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: MARCH. 9. 1959
22c. NAME OF CEMETERY OR CREMATORY: E. U. B. CEMETERY
22d LOCATION (City, town, or county) (State): MYERSVILLE FRED. CO. MD.

23. FUNERAL DIRECTOR'S SIGNATURE: John W. Burt — ADDRESS: BOONSBORO MD.
24a. REC'D BY REGISTRAR DATE MAR 11 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/55

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

3631 — Reg. Dist. No. 03637

1. PLACE OF DEATH
a. COUNTY: WASHINGTON — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 8 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: WASHINGTON COUNTY HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: MARYLAND — b. COUNTY: Frederick
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Smithsburg
d. STREET ADDRESS: ROUTE #1
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First: FLORA — Middle: EDITH — Last: MORGAN

4. DATE OF DEATH: Month: MARCH — Day: 20 — Year: 1959

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: APR 16, 1890

9. AGE (In years last birthday): 68 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE

10b. KIND OF BUSINESS OR INDUSTRY: Own home

11. BIRTHPLACE (State or foreign country): FREDERICK County Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William Brandenburg

14. MOTHER'S MAIDEN NAME: Rohann Pryor

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: none

17. INFORMANT — Address: Ralph E. Morgan, Smithsburg, Md. Rt. #1

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Left upper lobe pulmonary tuberculosis — months
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)
INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): arteriosclerotic heart disease

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.)

20c. TIME OF INJURY: Hour o. p. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Mar 10, 19 59 to March 20 19 59, that I last saw the deceased alive on March 20, 19 59, and that death occurred at 7:25 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: John C. Stauffer M.D. — ADDRESS (Street, city or town, state): 145 S. Prospect St. Hagerstown — DATE SIGNED

PHYSICIAN'S NAME (Type): John C. Stauffer

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Mar. 23, 1959

22c. NAME OF CEMETERY OR CREMATORY: St. Mark's Lutheran

22d. LOCATION (City, town, or county) (State): Wolfsville, Fred. Co. Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Paul E. Bittle — ADDRESS: Keysville, Md.

24a. REC'D BY REGISTRAR DATE: MAR 23 '59

24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

3632 — Reg. Dist. No. 03635

1. PLACE OF DEATH
a. COUNTY: [illegible] — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 2 WEEKS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Western Md. State Hosp.

2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission)
a. STATE: [illegible]
b. COUNTY: [illegible]
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): [illegible]
d. STREET ADDRESS: [illegible]
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Elmer Middle Ellsworth Last Myers

4. DATE OF DEATH: Month March Day 23 Year 1959

5. SEX: M

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: [illegible]

9. AGE (In years last birthday): 77 yrs

IF UNDER 1 YEAR: Months ___ Days ___ IF UNDER 24 HRS: Hours ___ Min ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Baker

10b. KIND OF BUSINESS OR INDUSTRY: Western Md. State Hosp.

11. BIRTHPLACE (State or foreign country): Fulton, Md.

12. CITIZEN OF WHAT COUNTRY: U.S.A.

13. FATHER'S NAME: Lewis Myers

14. MOTHER'S MAIDEN NAME: Mary Powell

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): — (If yes give war or dates of service): —

16. SOCIAL SECURITY NO.: 211-20-4715

17. INFORMANT: Address: MRS. ELMER MYERS, [illegible]

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Bronchopneumonia, bilateral — INTERVAL BETWEEN ONSET AND DEATH: 1 day

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) Pulmonary edema and congestion — 1 day

DUE TO

(c) cerebro-vascular accident — 4 months

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): cardiac hypertrophy and generalized atherosclerosis

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Hour ___ a. m. p. m. Month ___ Day ___ Year 19 ___

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)

21. I certify that I attended the deceased from March 9, 1959 to March 23 1959, that I lost saw the deceased alive on March 23, 1959, and that death occurred at 8:10 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Victor L. Ramos, M.D. — ADDRESS (Street, city or town, state): Western Md. State Hospital — DATE SIGNED: March 24, 1959

PHYSICIAN'S NAME (Type): Victor L. Ramos — Hagerstown, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: MARCH 27, 59

22c. NAME OF CEMETERY OR CREMATORY: Ellis Kirk Memorial Park

22d. LOCATION (City, town, or county) (State): Hagerstown, Md.

23. FUNERAL DIRECTOR'S SIGNATURE / ADDRESS: C. E. MYERS, 91 WILLIS ST., WESTMINSTER, MD.

24a. REC'D BY REGISTRAR DATE: MAR 26 '59

24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

V5 A15 (4)
15M 10/57

1

FOR STATE HEALTH DEPT.

M

I

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

0363

Reg. Dist. No.

1. PLACE OF DEATH — a. COUNTY: 3670 Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): rural Smithsburg
c. LENGTH OF STAY IN 1b: 13 years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) — a. STATE: Md. — b. COUNTY: Wash.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Smithsburg
d. STREET ADDRESS: 24 W. Water St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First John — Middle Arnold — Last Myers, Jr.
4. DATE OF DEATH: Month March — Day 30, — Year 19 59
5. SEX: male
6. COLOR OR RACE: white
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: May 12, 1945
9. AGE (In years last birthday): 13 yrs
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Hagerstown, Md.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: John Arnold Myers, Sr.
14. MOTHER'S MAIDEN NAME: Grace I. Reynolds
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: -
17. INFORMANT — Address: J. Arnold Myers, Sr., Smithsburg, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Open fracture skull
DUE TO (b): Multiple fractures of extremities Hemorrhage and shock
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Lost balance and fell over embankment at Stone Quarry
20c. TIME OF INJURY — Hour 5:15 p. m. — Month, Day, Year: Mar. 30 1959
20d. INJURY OCCURRED While at work ☐ Not while at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Stone Quarry
20f. (City or town) Rural — (County) Cavetown — (State) Wash Md

21. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: S. Robert Wells M.D.
EXAMINER'S NAME (Type): S. Robert Wells, M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 3-31-59

22a. BURIAL, CREMATION, REMOVAL (Specify): burial
22b. DATE THEREOF: 4-2-59
22c. NAME OF CEMETERY OR CREMATORY: Smithsburg Cemetery
22d. LOCATION (City, town, or county) Smithsburg, Md. (State)

23. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: Scott F. Minnich & Son, Smithsburg, Md
24c. REC'D BY REGISTRAR — DATE: APR 6 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Hawn

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15ME
SM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

3633 — Reg. Dist. No. — 03640

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 2 weeks
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Washington County Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Williamsport
d. STREET ADDRESS: 7 South Vermont
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Dorothy — Middle: Irene — Last: Pearman

4. DATE OF DEATH: Month: March — Day: 14 — Year: 1959

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: March 5, 1918

9. AGE (In years last birthday): 41 yrs. — IF UNDER 1 YEAR: Months: 0 — Days: 9 — IF UNDER 24 HRS.: Hours: — Min:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: At Home

11. BIRTHPLACE (State or foreign country): Funkstown, Md.

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Charles Edward Duffey

14. MOTHER'S MAIDEN NAME: Lily N. Dick

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or Unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Mr. Edward J. Pearman — Address: 7 S. Vermont St. Williamsport, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): UREMIA — INTERVAL BETWEEN ONSET AND DEATH: TWO WEEKS

592 X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): CARDIOVASCULAR RENAL DISEASE — UNKNOWN

DUE TO (c): CHRONIC GLOMERULONEPHRITIS — UNKNOWN

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): NONE

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY: Hour: a. m. / p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from FEB 23, 19[illegible], to MARCH 14, 1959, that I last saw the deceased alive on MARCH 13, 1959, and that death occurred at 1-47 A. M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Archie Robert Cohen M.D. — ADDRESS (Street, city or town, state): CLEAR SPRING MARYLAND — DATE SIGNED: MARCH 14, 1959

PHYSICIAN'S NAME (Type): ARCHIE ROBERT COHEN, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: March 16, '59

22c. NAME OF CEMETERY OR CREMATORY: Greenlawn Cem.

22d. LOCATION (City, town, or county) (State): Williamsport, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: [illegible] — ADDRESS: Williamsport, Md.

24a. REC'D BY REGISTRAR DATE: MAR 17 '59

24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by [illegible] page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3634

CERTIFICATE OF DEATH

Reg. Dist. No. 03641

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 36 yrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 1046 Carroll Hgts. Blvd.

2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Md. — b. COUNTY: Wash.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
d. STREET ADDRESS: 1046 Carroll Hgts. Blvd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: Kathryn — Middle: B — Last: Pearson

4. DATE OF DEATH: Month: 3 — Day: 11 — Year: 19 59

5 SEX: female — 6 COLOR OR RACE: white — 7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: July 14, 1912

9. AGE (In years last birthday): 46 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): school teanher

10b KIND OF BUSINESS OR INDUSTRY: Public schools

11. BIRTHPLACE (State or foreign country): Weverton, Md.

12 CITIZEN OF WHAT COUNTRY?: USA

13 FATHER'S NAME: Abner B. Binghham

14 MOTHER'S MAIDEN NAME: Annie L. Robosson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service)

16 SOCIAL SECURITY NO: 219-36-4084

INFORMANT: Robert E. Pearson — Address: Hagerstown, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Adenocarcinoma of Rectum
DUE TO: c Metastasis to liver
Conditions, if ony, which gave rise to immediate couse (a), stating the underlying cause last.
(b):
DUE TO
(c):

INTERVAL BETWEEN ONSET AND DEATH: 3-4 mos.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Undernutrition

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 24 Dec. 19 58, to 11 Mar. 19 59 that I last saw the deceased alive on 8-11 March 19 59, and that death occurred at 1:30 AM from the causes and on the date stated above

ACTUAL SIGNATURE: R. T. Binford, M.D. — ADDRESS (Street, city or town, state): 1135 Potomac Avenue — DATE SIGNED: 11 Mar. 59

PHYSICIAN'S NAME (Type): Richard T. Binford, M. D. — Hagerstown, Maryland

22a BURIAL, CREMATION, REMOVAL (Specify): cremation — 22b DATE THEREOF: 3-14-59 — 22c. NAME OF CEMETERY OR CREMATORY: Charles Evans Cemetery — 22d LOCATION (City, town, or county) (State): Reading Pa.

23 FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Fred W. Kraiss Hagerstown, Md.

24a REC'D BY REGISTRAR DATE: MAR 13 '59 — 24b REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3635

CERTIFICATE OF DEATH

03642

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 17 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Washington County Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md. — b. COUNTY: Wash.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cavetown
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First Lelia — Middle Myrtle — Last Phetteplace

4. DATE OF DEATH: Month March — Day 7, — Year 1959

5. SEX: female

6. COLOR OR RACE: white

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Feb. 21, 1888

9. AGE (In years last birthday): 71 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): seamstress

10b. KIND OF BUSINESS OR INDUSTRY: dry goods store

11. BIRTHPLACE (State or foreign country): Frederick Co., Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Melvin Wise

14. MOTHER'S MAIDEN NAME: Fannie Selsam

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 214-28-7430

17. INFORMANT — Address: Mrs. Doris Wise, Box 52, Cavetown, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 1 day

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b): Generalized Arteriosclerosis — 5 yrs.

DUE TO

(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY: Hour — a. m. / p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I **certify** that I attended the deceased from [illegible], 19[illegible], to [illegible], 19[illegible], that I last saw the deceased alive on [illegible], 19[illegible], and that death occurred at [illegible] M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Charles F. Kline M.D. — ADDRESS (Street, city or town, state): Smithsburg, Md. — DATE SIGNED: 3-9-59

PHYSICIAN'S NAME (Type): Charles F. [illegible] — Address: Smithsburg, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): burial

22b. DATE THEREOF: 3-10-59

22c. NAME OF CEMETERY OR CREMATORY: Smithsburg Cemetery

22d. LOCATION (City, town, or county) (State): Smithsburg, Md.

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Scott F. Minnich & Son, Smithsburg, Md.

24a. REC'D BY REGISTRAR — DATE: MAR 11 '59

24b. REGISTRAR'S SIGNATURE: Arthur S. Kline

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03643

3636

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: D.O.A.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Washington County Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
d. STREET ADDRESS: 818 S. Potomac Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: PATRICIA — Middle: KAY — Last: PITTS

4. DATE OF DEATH: Month: March — Day: 17 — Year: 1959

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: January 22, 1959

9. AGE (In years last birthday): yrs.
IF UNDER 1 YEAR: Months: 2 — Days:
IF UNDER 24 HRS: Hours: — Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Milwauke, Wisconsin

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Frank J. Gambino

14. MOTHER'S MAIDEN NAME: Lois Lorraine Pitts

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: none

17. INFORMANT: Miss. Lois L. Pitts — Address: Hagerstown, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute virus pneumonitis
492 X
DUE TO (b): Aspiration of vomitus
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18): none

20c. TIME OF INJURY: Hour: a. m. / p. m. — Month, Day, Year: none 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): none

20f. (City or town) — (County) — (State)

21. I certify that I took charge of the remains described above, held on Autopsy ☒, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: S. Robert Wells M.D.

EXAMINER'S NAME (Type): S. Robert Wells, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED: 3-18-59

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 3/19/1959

22c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery

22d. LOCATION (City, town, or county) (State): Hagerstown, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Suter-Rouzer Funeral Home
ADDRESS: Hagerstown, Md.

24a. REC'D BY REGISTRAR DATE: MAR 20 '59

24b. REGISTRAR'S SIGNATURE: Caroline L. Kinsey

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03644

3637

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 1 day
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Washington County Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
d. STREET ADDRESS: 1845 Woodland Way
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Beverly; Middle: Rich; Last: Pollard

4. DATE OF DEATH: Month: March; Day: 31; Year: 1959

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: March 30, 1959

9. AGE (In years last birthday) yrs.

IF UNDER 1 YEAR: Months; Days; Hours: 12; Min.
IF UNDER 24 HRS

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Hagerstown, Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Weir Pollard

14. MOTHER'S MAIDEN NAME: Hildegarde Rich

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO: none

17. INFORMANT: Mr. Weir Pollard Address: Hagerstown, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Premature
DUE TO
'776X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b):
DUE TO
(c):

INTERVAL BETWEEN ONSET AND DEATH

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour; a. m. p. m.; Month; Day; Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 3/30, 1959 to 3/31, 1959 that I last saw the deceased alive on 3/31, 1959, and that death occurred at 4:40 A.M., from the causes and on the date stated above.

ADDRESS (Street, city or town, state) DATE SIGNED

ACTUAL SIGNATURE: H. D. Bowman MD

PHYSICIAN'S NAME (Type): H. D. Bowman, MD 318 N. Potomac St. Hagerstown, Md

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 3/31/1959

22c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery

22d. LOCATION (City, town, or county) (State): Hagerstown, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Suter-Kpuzer Funeral Home
ADDRESS: Hagerstown, Maryland

24a. REC'D BY REGISTRAR DATE: APR 2 '59

24b. REGISTRAR'S SIGNATURE: Arthur S. Kline

1271XVO

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the Funeral Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2-57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
3638 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03645

Reg. Dist. No. 302

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 2 months
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Long Meadow Apts. Northern Ave.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
d. STREET ADDRESS: Long Meadow Apts. Northern Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: MAY — Middle: IRENE — Last: PREECE

4. DATE OF DEATH: Month: March — Day: 24 — Year: 19 59

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: July 21, 1910

9. AGE (In years last birthday): 48 yrs
IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Oxted Surrey, England

12. CITIZEN OF WHAT COUNTRY? England

13. FATHER'S NAME: Charles Putnam

14. MOTHER'S MAIDEN NAME: Annie ? James

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: none

17. INFORMANT: Leonard W. Preece — Address: Hagerstown, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Rheumatic Valvular Heart disease
414 X
DUE TO (b): Acute ventricular fibrillation
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.): None

20c. TIME OF INJURY: Hour: a. m. / p. m. None — Month: — Day: — Year: 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): None

20f. (City or town): — (County): — (State): —

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: S. Robert Wells M.D.
EXAMINER'S NAME (Type): S. Robert Wells, M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 3-25-59

22a. BURIAL, CREMATION, REMOVAL (Specify): Cremation
22b. DATE THEREOF: 3/30/1959
22c. NAME OF CEMETERY OR CREMATORY: Cedar Hill Cemetery
22d. LOCATION (City, town, or county): Washington, (State): D.C.

23. FUNERAL DIRECTOR'S SIGNATURE: Suter-Rouzer Funeral Home
ADDRESS: Hagerstown, Md.

24a. REC'D BY REGISTRAR DATE: MAR 30 '59
24b. REGISTRAR'S SIGNATURE: Carlton L. Krauss

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

3639 — Reg. Dist. No. 03645

1 PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 1½ days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Washington County Hospital

2. USUAL RESIDENCE (Where deceased lived — If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Harpers Ferry RFD #1
d. STREET ADDRESS: Harpers Ferry RFD #1
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First: Roger — Middle: Lee — Last: Price

4. DATE OF DEATH: Month: March — Day: 21 — Year: 19 59

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED [ ] NEVER MARRIED [X] WIDOWED [ ] DIVORCED [ ]

8. DATE OF BIRTH: Jan. 18 1957

9. AGE (In years last birthday): 2 yrs.

IF UNDER 1 YEAR: Months: 2 — Days: 3 — IF UNDER 24 HRS: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): Hagerstown Md.

12. CITIZEN OF WHAT COUNTRY?: U.S.A

13. FATHER'S NAME: Harvey Jefferson Price

14. MOTHER'S MAIDEN NAME: Thelma M. Miller

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No / No

16. SOCIAL SECURITY NO: None

17. INFORMANT: Mr. Harvey J. Price — Address: Harpers Ferry Md. RFD #1

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Bacterial pneumonitis - Prob. Staph — INTERVAL BETWEEN ONSET AND DEATH: 2 days

491X

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Viral infection and pneumonitis in early March, 1959.

19. WAS AUTOPSY PERFORMED? YES [ ] NO [ ]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month, Day, Year, Hour o. m. p. m. 19

20d. INJURY OCCURRED While at work [ ] Not while at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from March 6, 1959, to March 21, 1959, that I last saw the deceased alive on March 21, 1959, and that death occurred at 6:15 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Walter H. Shealy M.D. — ADDRESS (Street, city or town, state): Sharpsburg, Md. — DATE SIGNED: 3/22/59

PHYSICIAN'S NAME (Type): Walter H. Shealy M. D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: March 23-59

22c. NAME OF CEMETERY OR CREMATORY: Mt. View Cemetery

22d. LOCATION (City, town, or county) (State): Sharpsburg Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Albert L. Kaufman — ADDRESS: Williamsport Md

24a. REC'D BY REGISTRAR DATE: MAR 24 '59

24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3640

CERTIFICATE OF DEATH

Reg. Dist. No. 03647

1 PLACE OF DEATH
a. COUNTY: Washington — MARYLAND

2. USUAL RESIDENCE (Where deceased lived — If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Washington

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown

c. LENGTH OF STAY IN 1b: 1 month

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Rural, Smithsburg

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Washington County Hospital

d. STREET ADDRESS: R.D. 2 Smithsburg

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Russell — Middle: Samuel — Last: Pryor

4. DATE OF DEATH: Month: March — Day: 21 — Year: 1959

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 3/27/1897

9. AGE (In years last birthday): 61 yrs — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): store operator

10b. KIND OF BUSINESS OR INDUSTRY: self employed

11. BIRTHPLACE (State or foreign country): Md. Wolfsville, Frederick Co.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Samuel C. Pryor

14. MOTHER'S MAIDEN NAME: Ida E. Swope

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT — Address: Alvie R. Pryor Smithsburg, Md. R.D. 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Gastrointestinal hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 2 weeks

153.8

DUE TO (b): Carcinoma of colon with liver and — 18 mos

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c): peritoneal metastases

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Feb. 20, 1959, to Mar. 21, 1959, that I last saw the deceased alive on Mar. 21, 1959, and that death occurred at 9:45 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: R. S. Stauffer M.D. — ADDRESS (Street, city or town, state): 145 S. Prospect St Hagerstown, Md — DATE SIGNED

PHYSICIAN'S NAME (Type): R.S. STAUFFER

22a BURIAL, CREMATION, REMOVAL (Specify): Burial — 22b. DATE THEREOF: 3/24/59 — 22c NAME OF CEMETERY OR CREMATORY: Wolfsville, Lutheran — 22d. LOCATION (City, town, or county): Frederick, Co. (State): Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Walter Y. Grove — ADDRESS: Waynesboro, Pa.

24a. REC'D BY REGISTRAR DATE: MAR 26 '59 — 24b REGISTRAR'S SIGNATURE: Arthur S. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3671

CERTIFICATE OF DEATH

03648

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1. PLACE OF DEATH
a. COUNTY: ~~WASHINGTON COUNTY~~ Hancock Md — MARYLAND
Hancock Rest Home
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hancock Maryland.
c. LENGTH OF STAY IN 1b: 16 Months
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Hancock Rest Home

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Ridgely
b. COUNTY: W. Va
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): R.F.D.#1 Ridgely, W.Va.
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Mrs. Middle Nellie Last Ralston

4. DATE OF DEATH: Month March Day 29 Year 1959

5. SEX: Fem.

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Aug 9 74

9. AGE (In years last birthday): 84 yrs.
IF UNDER 1 YEAR / IF UNDER 24 HRS — Months / Days / Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Martinsburg W Va

12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: John C. Hansrote

14. MOTHER'S MAIDEN NAME: Laura Reeder

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: No

17. INFORMANT — Address: Copies from E H Presnell Report Entering

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a): Intestinal Obstruction — INTERVAL BETWEEN ONSET AND DEATH: 72 hrs
570.2
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Cardiac Deficiency

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 3/24, 1959, to 3/29, 1959, that I last saw the deceased alive on 3/25, 1959, and that death occurred at 6:45 AM, from the causes and on the date stated above.

ACTUAL SIGNATURE: H E Tabler M.D. — ADDRESS (Street, city or town, state): Hancock Maryland. — DATE SIGNED

PHYSICIAN'S NAME (Type): H.E. Tabler — Hancock Maryland.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 4-1-59

22c. NAME OF CEMETERY OR CREMATORY: Davis Memorial Cem.

22d LOCATION (City, town, or county) (State): Cumberland, Md.

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: James F. Scarpelli Cumberland, Md.

24a. REC'D BY REGISTRAR — DATE: APR 1 '59

24b. REGISTRAR'S SIGNATURE: Arthur S. Travis

1

FOR STATE HEALTH DEPT.

M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

3641

Reg. Dist. No. 03643

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND

2. USUAL RESIDENCE (Where deceased lived — If institution, Residence before admission)
a. STATE: Maryland — b. COUNTY: Washington

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown

c. LENGTH OF STAY IN 1b: Life

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 03 Hagerstown

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 229 Alexander Street

d. STREET ADDRESS: 1 229 Alexander Street

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: IOIA — Middle: DEVILLE — Last: RANDALL

4. DATE OF DEATH: Month: March — Day: 3 — Year: 1959

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: April 8, 1871

9. AGE (In years last birthday): 87 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Hagerstown, Md

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William Baker

14. MOTHER'S MAIDEN NAME: Barlup

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: none

17. INFORMANT: Miss Catherine Randall — Address: 229 Alexander St- Hagerstown, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Arteriosclerotic myocardial heart disease — INTERVAL BETWEEN ONSET AND DEATH: 3 yrs

4d.d.1

DUE TO (b): with myocardial failure grad e iv

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18): None

20c. TIME OF INJURY: Hour o. m. p. m. — Month, Day, Year: none 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): none

20f. (City or town) — (County) — (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Hamicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: S. Robert Wells M.D.

EXAMINER'S NAME (Type): S. Robert Wells, M.D.

CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED: 3-4-59

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 3-6-59

22c. NAME OF CEMETERY OR CREMATORY: Rest Haven Cemetery

22d. LOCATION (City, town, or county) (State): Hagerstown Wash Md

23. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: Rest Haven Funeral Chapel Inc-Hagerstown, Md

24a. REC'D BY REGISTRAR DATE: MAR 6 '59

24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

Wm. C. Frost & Bro.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary please execute the [illegible] certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 4 may be retained in your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

YS ATSME
BM 2'57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3642

CERTIFICATE OF DEATH

Reg. Dist. No. 03650

1. PLACE OF DEATH
a. COUNTY: WASHINGTON — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAGERSTOWN
c. LENGTH OF STAY IN 1b: 30 YRS.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: WASHINGTON COUNTY HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: WASHINGTON
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAGERSTOWN
d. STREET ADDRESS: 312 S. POTOMAC ST.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First HANNAH — Middle MARIE — Last RHOADS

4. DATE OF DEATH: Month MARCH — Day 18 — Year 19 59

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 10/25/1909

9. AGE (In years last birthday): 49 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): JEWELLER

10b. KIND OF BUSINESS OR INDUSTRY: RETAIL STORE

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: GEORGE F. BAKER

14. MOTHER'S MAIDEN NAME: ANNA CARTER

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service)

16. SOCIAL SECURITY NO: 160-16-2289

17. INFORMANT: MR. CARLTON RHOADS — Address: HAGERSTOWN MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Reticulum Cell sarcoma — INTERVAL BETWEEN ONSET AND DEATH: 6-8 mos.

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

(b)

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Pernicious anemia; Terminal bronchopneumonia — 19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY: Month, Day, Year; Hour a. m. / p. m.; 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 18 Mar. 19 59 to 18 Mar. 19 59 that I last saw the deceased alive on 18 Mar. 19 59, and that death occurred at 9 p. M. from the causes and on the date stated above.

ACTUAL SIGNATURE: Richard T. Binford M.D. — ADDRESS (Street, city or town, state): 1135 POTOMAC AVE. HAGERSTOWN, MD. — DATE SIGNED: 20 MAR. 59

PHYSICIAN'S NAME (Type): RICHARD T. BINFORD, MD.

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: 3/21/59

22c. NAME OF CEMETERY OR CREMATORY: ROSE HILL CEM.

22d. LOCATION (City, town, or county) (State): HAGERSTOWN MD.

23. FUNERAL DIRECTOR'S SIGNATURE: W. J. Hormel — ADDRESS: Hagerstown, Md.

24a. REC'D BY REGISTRAR DATE: MAR 23 '59

24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS ATS (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

3672 — Reg. Dist. No. 03651

1. PLACE OF DEATH
a. COUNTY: WASHINGTON — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): FUNKSTOWN
c. LENGTH OF STAY IN 1b: 12 YEARS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 15 EAST MAPLE STREET

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: MARYLAND — b. COUNTY: WASHINGTON
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X FUNKSTOWN
d. STREET ADDRESS: 15 EAST MAPLE STREET
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: ELMER — Middle: SILAS — Last: RIDENOUR
4. DATE OF DEATH: Month: MARCH — Day: 19 — Year: 1959

5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: FEBRUARY 6 1882
9. AGE (In years last birthday): 77 yrs.
IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED OPERATOR OF TOURIST COURT
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): BEAVER CREEK WASH.CO.MD.U.S.A.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: ANDREW RIDENOUR
14. MOTHER'S MAIDEN NAME: JANE DOYLE

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): NO (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: NONE
17. INFORMANT: MRS.ELIZABETH RIDENOUR — Address: 15 E.MAPLE ST. FUNKSTOWN MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Papillary Carcinoma of Bladder
DUE TO (b):
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
INTERVAL BETWEEN ONSET AND DEATH: 2 yrs.

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Advanced degenerative arthritis of Spine
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year, Hour, a. m. p. m.
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that I attended the deceased from May 15 19 57 to Mar 19 19 59 that I last saw the deceased alive on Mar 19 19 59, and that death occurred at 11 p M, from the causes and on the date stated above.
ACTUAL SIGNATURE: Edward W Ditto III M.D.
ADDRESS (Street, city or town, state): 217 W. Washington St. Hagerstown, Md.
DATE SIGNED: 3-21-59
PHYSICIAN'S NAME (Type): Edward W. Ditto III M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: MARCH 23 59
22c. NAME OF CEMETERY OR CREMATORY: BOONSBORO CEMETERY
22d. LOCATION (City, town, or county) (State): BOONSBORO WASH.CO.MD.
23. FUNERAL DIRECTOR'S SIGNATURE: John H. Bast — ADDRESS: Boonsboro Md
24a. REC'D BY REGISTRAR: MAR 26 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Kreps

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03652

CERTIFICATE OF DEATH

3673

Reg. Dist. No 302

1 PLACE OF DEATH
a COUNTY Washington — MARYLAND

b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Breathedsville

c. LENGTH OF STAY IN 1b 22 Months

2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission)
a STATE Md. b COUNTY

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE

d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Md State Reformatory for Males

d STREET ADDRESS 2727 Fait Ave.

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print) First HOWARD Middle CONRAD Last RIEMER

4 DATE OF DEATH Month March Day 12 Year 1959

5 SEX M

6. COLOR OR RACE W

7 MARRIED ☐ NEVER MARRIED ☑ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH 7-22-39

9 AGE (In years last birthday) yrs

IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer

10b KIND OF BUSINESS OR INDUSTRY ----

11 BIRTHPLACE (State or foreign country) [illegible]

12 CITIZEN OF WHAT COUNTRY? [illegible]

13. FATHER'S NAME JAMES RIEMER

14. MOTHER'S MAIDEN NAME ISABELLE McDONALD

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) ----

16. SOCIAL SECURITY NO. 217-34-2795 unable to locate

INFORMANT Address Mrs Isabelle Presson 2727 Fait Ave Baltimore 24 Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lobar Pneumonia — INTERVAL BETWEEN ONSET AND DEATH 6 days

490X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c)

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that I attended the deceased from Mar 7, 1959, to Mar 12, 1959 that I last saw the deceased alive on Mar 12, 1959, and that death occurred at 1:45 P.M., from the causes and on the date stated above

ACTUAL SIGNATURE Robert P. Conrad M.D

ADDRESS (Street, city or town, state) 137 W. Washington

DATE SIGNED 3-13-59

PHYSICIAN'S NAME (Type) Robert P. Conrad Hagerstown, Md

22a BURIAL, CREMATION, REMOVAL (Specify) Burial

22b DATE THEREOF 3/16/59

22c NAME OF CEMETERY OR CREMATORY ST. MATTHEWS CEM.

22d LOCATION (City, town, or county) [illegible] (State) Md.

23 FUNERAL DIRECTOR'S SIGNATURE [illegible] ADDRESS 701 S. CARLING ST. Balto 24 Md.

24a. REC'D BY REGISTRAR DATE MAR 17 59

24b. REGISTRAR'S SIGNATURE [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death [illegible] may be required by the hospital or attending physician

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, killed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death

VS A15 (4) 15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3643

CERTIFICATE OF DEATH

036556

Reg. Dist. No. 302

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 14 Yrs
d. NAME OF HOSPITAL (If not in hospitol, give street oddress) OR INSTITUTION: 635 George St

2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
d. STREET ADDRESS: 635 George St
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First RUSSELL Middle JACK Last RIFFEE

4. DATE OF DEATH: Month March Day 29 Year 1959

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Aug 1 1908

9. AGE (In years last birthday): 50 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS: Hours Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Guard State Reformatory

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Va Woodstock Shenandoah Co

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Floyd Riffee

14. MOTHER'S MAIDEN NAME: Lucy V. Larkin

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): ------

16. SOCIAL SECURITY NO: 214-05-7593

17. INFORMANT: Mrs Violet I. Riffee Address: 635 George St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c)]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Bronchitis from Hagerstown, Md. from Cerebral Hemorrhage from
DUE TO (b): Cancer of Lung (primary)
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: days, months, years

162.1

Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that I attended the deceased from [illegible], 19[illegible] to [illegible], 19[illegible], that I last saw the deceased alive on [illegible], 19[illegible], and that death occurred at [illegible] M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Howard N. Weeks M.D. ADDRESS (Street, city or town, state): [illegible] DATE SIGNED: 3/30/59

PHYSICIAN'S NAME (Type): Howard N. Weeks, M.D. [illegible]

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 4/1/59

22c. NAME OF CEMETERY OR CREMATORY: Rest Haven Cemetery

22d. LOCATION (City, town, or county) (State): Hagerstown Wash. Co Md.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Andrew K. Coffman Hagerstown Md.

24a. REC'D BY REGISTRAR DATE: APR 2 '59

24b. REGISTRAR'S SIGNATURE: Clothey L. Hawn

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by [illegible] page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 [illegible] the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Page 4

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3674 **CERTIFICATE OF DEATH** Reg. Dist. No. 03654

1. PLACE OF DEATH
a. COUNTY: WASHINGTON — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BOONSBORO
c. LENGTH OF STAY IN 1b: 30 YEARS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: NORTH MAIN STREET

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: WASHINGTON
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BOONSBORO
d. STREET ADDRESS: NORTH MAIN STREET
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ANNIE Middle M. Last ROHRER
4. DATE OF DEATH: Month MARCH Day 3 Year 1959
5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: AUGUST 1 1875
9. AGE (In years last birthday): 83 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSE WIFE
10b. KIND OF BUSINESS OR INDUSTRY: OWN HOME
11. BIRTHPLACE (State or foreign country): LOCUST GROVE WASH.CO.MD. U.S.A.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: GEORGE SHIFLER
14. MOTHER'S MAIDEN NAME: ELIZABETH HUFFER
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) NO (If yes, give war or dates of service) NONE
16. SOCIAL SECURITY NO: NONE
17. INFORMANT — Address: MRS. ALBERT SHANK BOONSBORO MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Generalized Arteriosclerosis
DUE TO (b): myocardial disease
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):
4 d d.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month Day Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that I attended the deceased from Aug, 1957, to Mar 3, 1959, that I last saw the deceased alive on Feb 27, 1959, and that death occurred at ____ M, from the causes and on the date stated above.

SIGNATURE: Elmer Harp M.D. ADDRESS (Street, city or town, state): Middletown DATE SIGNED: 3-3-59
PHYSICIAN'S NAME (Type): J. ELMER HARP

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: MARCH 5 1959
22c. NAME OF CEMETERY OR CREMATORY: BOONSBORO CEMETERY
22d. LOCATION (City, town, or county) (State): BOONSBORO WASH.CO,MD.

23. FUNERAL DIRECTOR'S SIGNATURE: John A. Bast ADDRESS: Boonsboro Md
24a. REC'D BY REGISTRAR DATE: MAR 11 '59
24b. REGISTRAR'S SIGNATURE: Esther L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 only should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3644 **CERTIFICATE OF DEATH** 03655

Reg. Dist. No.

TO BE FILLED OUT BY ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 2 weeks
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Western Maryland State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)
a. STATE: Md. b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
d. STREET ADDRESS: 409 Liberty St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Ross Middle: (none) Last: Semler
4. DATE OF DEATH: Month: March Day: 5 Year: 1959
5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: July 2, 1907
9. AGE (In years last birthday): 51 yrs
IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS: Hours: Min:
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter
10b. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): Hagerstown, Washington Co. U.S.A.
12. CITIZEN OF WHAT COUNTRY:
13. FATHER'S NAME: Thomas L. Semler
14. MOTHER'S MAIDEN NAME: Mary Cramer
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 214-09-3870
17. INFORMANT Address: Miss Ruth Semler, 131 McComas St., Hag. Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	pneumonia, bilateral	2 days
DUE TO		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last — (b)	broncho-esophageal fistula	7 weeks
DUE TO (c)	carcinoma of esophagus	9 weeks

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): 19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour: o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Feb. 19, 1959, to March 5, 1959, that I last saw the deceased alive on March 5, 1959, and that death occurred at 2:20 AM, from the causes and on the date stated above

ACTUAL SIGNATURE: Victor L. Ramos, M.D. ADDRESS (Street, city or town, state): Western Maryland State Hosp. DATE SIGNED: March 5, 59

PHYSICIAN'S NAME (Type): Victor L. Ramos Hagerstown, Maryland.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 3/7/59
22c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery
22d. LOCATION (City, town, or county) (State): Hagerstown Wash Co Md

23. FUNERAL DIRECTOR'S SIGNATURE: H. K. Hoffman ADDRESS: Hagerstown Md
24a. REC'D BY REGISTRAR DATE: MAR 11 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Krause

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3645

03656

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 15 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Washington County Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Rural Sharpsburg
d. STREET ADDRESS: R.F.D. 2
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First EARL — Middle HARRY — Last SHANTZ

4. DATE OF DEATH: Month March — Day 29 — Year 19 59

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒
8. DATE OF BIRTH: September 7, 1882
9. AGE (In years last birthday): 76 yrs
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Laborer
10b. KIND OF BUSINESS OR INDUSTRY: Coal Company
11. BIRTHPLACE (State or foreign country): Washington Co., Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: George Shantz
14. MOTHER'S MAIDEN NAME: Bessie Linebaugh

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 213-16-1455
17. INFORMANT — Address: Mr. Charles H. Shantz Boonsboro, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a): Arteriosclerotic Heart disease — INTERVAL BETWEEN ONSET AND DEATH: 2 yrs.
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Pulmonary Emphysema
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year — Hour a. m. p. m. — 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that I attended the deceased from March 20, 19 59, to March 29, 19 59, that I last saw the deceased alive on March 29, 19 59, and that death occurred at 8 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Paul Harrison M.D.
ADDRESS (Street, city or town, state): Hagerstown, Maryland
DATE SIGNED:
PHYSICIAN'S NAME (Type): Dr. Paul Harrison

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 3/1/1959
22c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery
22d. LOCATION (City, town, or county) (State): Hagerstown Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Suter-Rouzer Funeral Home
ADDRESS: Hagerstown, Md.
24a. REC'D BY REGISTRAR DATE: APR 2 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Hawk

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03657

3646

CERTIFICATE OF DEATH

Reg. Dist. No. 302

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

1. PLACE OF DEATH a. COUNTY: Washington — MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission.) a. STATE: Maryland — b. COUNTY: Washington
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown — c. LENGTH OF STAY IN 1b: 8 months	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 533 Brown Ave.	d. STREET ADDRESS: 533 Brown Ave. — e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
PAULA		SHEA	March	26	1959

5. SEX	6. COLOR OR RACE	7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday) yrs	IF UNDER 1 YEAR: Months	Days	IF UNDER 24 HRS: Hours	Min
Female	White		July 19, 1958	8	7			

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
none		Hagerstown, Maryland	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Martin M. Shea	Margaret Scully

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT	Address
no	none	Martin M. Shea	Hagerstown, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Anemia, Dehydration, Malnutrition	3 mos.
DUE TO		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)	Cerebral trauma	8 mos.
DUE TO (c)	Birth Injury	8 mos.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) — 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour / Month, Day, Year	20d. INJURY OCCURRED While at work ☐ Not while at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
a. m. / p. m. 19					

21. I certify that I attended the deceased from Dec. 19 58, to 3-26 19 59, that I last saw the deceased alive on 3-25 19 59, and that death occurred at 4:40 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: John D. Tucci M.D. — ADDRESS (Street, city or town, state): 302 E. Potomac St. Hagerstown, Md. — DATE SIGNED: 3-26-59

PHYSICIAN'S NAME (Type): JOHN D. TUCCI

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	3/28/1959	Calvary Cem.	Youngstown, Ohio

23. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS	24a. REC'D BY REGISTRAR DATE	24b. REGISTRAR'S SIGNATURE
Suter-Kuzer Funeral Home	Hagerstown, Md.	MAR 30 '59	Arthur L. Kraus

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

3675

03658 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Leitersburg
c. LENGTH OF STAY IN 1b: 1 day
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Brooklane Mental Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Penna. — b. COUNTY: York Co.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural N. Codorus Twp.
d. STREET ADDRESS: R. D. # 1 Spring Grove
e. RESIDENCE ON A FARM: YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First: Adam — Middle: B. — Last: Shearer
4. DATE OF DEATH: Month: March — Day: 24 — Year: 1959
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH: Oct. 1, 1890
9. AGE (In years last birthday): 68 yrs
IF UNDER 1 YEAR: Months: 5 Days: 23 — IF UNDER 24 HRS: Hours: Min.:
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Farmer
10b. KIND OF BUSINESS OR INDUSTRY: Farm Owner
11. BIRTHPLACE (State or foreign country): York Co. Penna.
12. CITIZEN OF WHAT COUNTRY?: USA
13. FATHER'S NAME: Jacob J. Shearer
14. MOTHER'S MAIDEN NAME: Susan Brillhart
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 170-24-1742
17. INFORMANT: Jacob a Shearer — Address: R. D. # 1 Spring Grove, Pa.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Suffocation by drowning
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):
INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Mentally Ill
19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. EXTERNAL CAUSE WAS PRIMARY [ ] or CONTRIBUTING [ ] CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.): Drowned self in brook near Brooklane Mental Hospital
20c. TIME OF INJURY: Hour: 12:00 p.m. — Month, Day, Year: N Mar. 24 1959
20d. INJURY OCCURRED: While at work [ ] Not while at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Brook
20f. (City or town) (County) (State): Rural Leitersburg Wash Md

21. I certify that I took charge of the remains described above, held an Autopsy [ ], Inspection [X], Inquiry [ ], and in my opinion death resulted from: Natural causes [ ], Accident [ ], Suicide [X], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE: S. Robert Wells M.D.
CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]
DATE SIGNED: Mar. 24'59
EXAMINER'S NAME (Type): S. Robert Wells, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Mar. 28, 1959
22c. NAME OF CEMETERY OR CREMATORY: Jefferson Cemetery
22d. LOCATION (City, town, or county) (State): Codorus, York Co. Pa.

23. FUNERAL DIRECTOR'S SIGNATURE: J. J. Keenan
ADDRESS: McSherrystown, Pa.
24a. REC'D BY REGISTRAR DATE: MAR 30 '59
24b. REGISTRAR'S SIGNATURE: Orilla L. Hauer

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15ME
5M 2'57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

03659

Reg. Dist. No. 3647

1. PLACE OF DEATH
a. COUNTY Washington MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown
c. LENGTH OF STAY IN 1b 30 years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 463 W. Franklin St.

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Washington
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown
d. STREET ADDRESS 463 W. Franklin St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First John Middle Ripple Last Sheeler
4. DATE OF DEATH Month March Day 17 Year 1959
5 SEX Male
6. COLOR OR RACE White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH 5-13-75
9. AGE (In years last birthday) 83 yrs
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer
10b. KIND OF BUSINESS OR INDUSTRY general
11. BIRTHPLACE (State or foreign country) Waynesboro Pa.
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME Thomas Sheeler
14. MOTHER'S MAIDEN NAME Albert (Maiden)

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) ---
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 219-05-2825
17. INFORMANT Address Franklin T. Sheeler Gaithersburg Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Left Hemiplegia — INTERVAL BETWEEN ONSET AND DEATH 3 wk
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Arteriosclerosis — 5 yr
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED White at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that I attended the deceased from Oct 27, 19__, to 3/16, 1959, that I last saw the deceased alive on 3/16, 1959, and that death occurred at 1230 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE Robert V. Campbell M.D.
ADDRESS (Street, city or town, state) 145 W. Washington
DATE SIGNED

PHYSICIAN'S NAME (Type) Robert V. Campbell Hagerstownn Md.

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 3-19-59
22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery
22d. LOCATION (City, town, or county) (State) Hagerstown Md.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Scott F. Minnich & Son Hagerstown Md.
24a. REC'D BY REGISTRAR DATE MAR 20 '59
24b. REGISTRAR'S SIGNATURE Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in [illegible] the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and [illegible] should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3648 CERTIFICATE OF DEATH

Reg. Dist. No. 03660

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 57 yrs
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: 1135 Oak Hill Ave.,

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md. b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 03 Hagerstown
d. STREET ADDRESS: 1135 Oak Hill Ave.,
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
Siddie	F	Shupp	3	16	19 59

5 SEX	6 COLOR OR RACE	7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	8. DATE OF BIRTH	9 AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS Hours	Min.
female	white		Feb. 22, 1876	83 yrs				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b KIND OF BUSINESS OR INDUSTRY	11 BIRTHPLACE (State or foreign country)	12 CITIZEN OF WHAT COUNTRY?
home duties	home	Winchester, Va.	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Isaac H. Faulkner	Siddie Seevers

15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO	INFORMANT Address
no	none	Frank F. Shupp Hagerstown, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: Sudden

DUE TO (b): Arteriosclerotic heart disease — Years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4.20.0

DUE TO (c):

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Gastrointestinal virus infection — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19	20d INJURY OCCURRED While at work ☐ Not while at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Mar 3, 1959, to Mar 16, 1959, that I last saw the deceased alive on Mar 16, 1959, and that death occurred at 2 P. M., from the causes and on the date stated above.

ACTUAL SIGNATURE: R S Stauffer M.D. — ADDRESS (Street, city or town, state): 145 S. Prospect St — DATE SIGNED: Mar. 17, 1959

PHYSICIAN'S NAME (Type): R. S. STAUFFER — Hagerstown Md

22a BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
burial	3-19-59	Rest Haven	Hagerstown Md.

23 FUNERAL DIRECTOR'S SIGNATURE ADDRESS	24a. REC'D BY REGISTRAR DATE	24b. REGISTRAR'S SIGNATURE
Fred W. Kraiss Hagerstown, Md.	MAR 19 '59	Catherine S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3649 CERTIFICATE OF DEATH

Reg. Dist. No. 03661

1. PLACE OF DEATH
a. COUNTY: WASHINGTON — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAGERSTOWN
c. LENGTH OF STAY IN 1b: 60 YRS.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 116 GREENBERRY RD.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: WASHINGTON
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 03 HAGERSTOWN
d. STREET ADDRESS: 116 GREENBERRY RD.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First LULA — Middle ESTELLA — Last SINNISEN

4. DATE OF DEATH: Month MARCH — Day 20 — Year 19 59

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 3/8/1880

9. AGE (In years last birthday): 79 yrs.

IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE

10b. KIND OF BUSINESS OR INDUSTRY: HOME

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: GEORGE A. SUMMER

14. MOTHER'S MAIDEN NAME: CAROLINE KING

15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)

16. SOCIAL SECURITY NO: NONE

17. INFORMANT: MRS. MILDRED HOUSER — Address: HAGERSTOWN MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cerebral Embolism — INTERVAL BETWEEN ONSET AND DEATH: 2 Minutes

420.0

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Arteriosclerotic Heart Disease — Indef.

DUE TO (c):

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): X X

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month, Day, Year — Hour a.m. p.m. — 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1954 to March 20 19 59, that I last saw the deceased alive on March 20 19 59, and that death occurred at 12:20 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: B B Kneisley M.D. — ADDRESS (Street, city or town, state): 148 West Washington St. — DATE SIGNED: 3/21/59

PHYSICIAN'S NAME (Type): Dr. B. B. Kneisley, — Hagerstown, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: 3/22/59

22c. NAME OF CEMETERY OR CREMATORY: ROSE HILL CEM.

22d. LOCATION (City, town, or county) (State): HAGERSTOWN MD.

23. FUNERAL DIRECTOR'S SIGNATURE: W. J. Hemmit — ADDRESS: Hagerstown, Md.

24a. REC'D BY REGISTRAR DATE: MAR 24 '59

24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers—Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3650

CERTIFICATE OF DEATH

04875
Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 1 day
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Wash. County Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 03 Hagerstown
d. STREET ADDRESS: 4 East 4th St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Debora — Middle: Ann — Last: Smith

4. DATE OF DEATH: Month: March — Day: 8, — Year: 19 59

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 3/8/59

9. AGE (In years last birthday) yrs.

IF UNDER 1 YEAR: Months | Days — IF UNDER 24 HRS: Hours: 1 | Min.: 15

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Robert James Smith

14. MOTHER'S MAIDEN NAME: Darlene Virginia Marshall

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO

17. INFORMANT — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Premature separation Placenta — INTERVAL BETWEEN ONSET AND DEATH: 1 hr.

761.5

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. ji. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from March 8, 19 59 to March 8, 19 59, that I last saw the deceased alive on March 8, 19 59, and that death occurred at 12:53 AM from the causes and on the date stated above.

ACTUAL SIGNATURE: Paul Harrison M.D. — ADDRESS (Street, city or town, state): 318 N. Pot. St., Hagerstown, Md. — DATE SIGNED: 4/22/59

PHYSICIAN'S NAME (Type): Paul Harrison, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Cremation

22b. DATE THEREOF: 3/9/59

22c. NAME OF CEMETERY OR CREMATORY: Wash. Co. Hospital

22d. LOCATION (City, town, or county) (State): Hagerstown, Md.

23. FUNERAL DIRECTOR'S SIGNATURE / ADDRESS: Paul Harrison M.D.

24a. REC'D BY REGISTRAR DATE: APR 27 '59

24b REGISTRAR'S SIGNATURE: Arthur L. Thomas

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 1a Filed 39 3-4-59 et

3676

CERTIFICATE OF DEATH

Reg. Dist. No. 0366

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Boonesboro
c. LENGTH OF STAY IN 1b: two weeks
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Reeder Nursing Home

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural- Hancock
d. STREET ADDRESS: Timber Ridge Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Harry — Middle C — Last Snyder
4. DATE OF DEATH: Month March — Day 3 — Year 1959
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: March 24, 1882
9. AGE (In years last birthday): 76 yrs — IF UNDER 1 YEAR: Months 11 Days 9 — IF UNDER 24 HRS: Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10b. KIND OF BUSINESS OR INDUSTRY: Orchard Work
11. BIRTHPLACE (State or foreign country): Millstone, Md.
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: John H. Snyder
14. MOTHER'S MAIDEN NAME: Mary E. McCarty
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 220-09-7859
17. INFORMANT: Mrs. Elsie Sharer — Address: 547 W. Wilson Blvd. Hagerstown, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Generalized arteriosclerosis — INTERVAL BETWEEN ONSET AND DEATH: 5 yrs
DUE TO
420.0
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour o. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Feb 23, 19 59, to March 3, 19 59, that I last saw the deceased alive on March 3, 19 59, and that death occurred at 8:15 M, from the causes and on the date stated above.

ACTUAL SIGNATURE: [signature] M.D. — ADDRESS (Street, city or town, state): Boonesboro — DATE SIGNED: 3/4/59

PHYSICIAN'S NAME (Type): C. Wilson Md

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 3/7/59
22c. NAME OF CEMETERY OR CREMATORY: Stone Bridge Church Dunkard Church Cemetery
22d. LOCATION (City, town, or county) (State): Orchard Ridge Road Wash. Co. Md.

23. FUNERAL DIRECTOR'S SIGNATURE: [signature] ADDRESS: Hagerstown Md.
24a. REC'D BY REGISTRAR: DATE MAR 6 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03663

3677

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cascade
c. LENGTH OF STAY IN 1b: 7 weeks
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Haun Convalescent & Care Home

2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission)
a. STATE: Penna. — b. COUNTY: Franklin
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Waynesboro
d. STREET ADDRESS: 206 S. Potomac St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Mary — Middle: M. — Last: Stoner

4. DATE OF DEATH: Month: 3 — Day: 15 — Year: 1959

5. SEX: female

6. COLOR OR RACE: white

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 2/16/1872

9. AGE (In years last birthday): 87 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House keeper

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Leitersburg, Md.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Jacob B. Stoner

14. MOTHER'S MAIDEN NAME: Elizabeth O. Tritle

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO:

17. INFORMANT — Address: Penna.
Mrs. Paul H. Weagley, 705 Maple St. Waynesboro,

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): arteriosclerotic cardiovascular [illegible] — INTERVAL BETWEEN ONSET AND DEATH: 2 yrs

422.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Old age — 2 yrs

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from March 2, 1959 to March 15, 1959, that I last saw the deceased alive on March 14, 1959, and that death occurred at 1:25 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: Robert A. Wolfe M.D. — ADDRESS (Street, city or town, state): 26 W. Main St. Waynesboro, Pa. — DATE SIGNED: Mar. 17, 1959

PHYSICIAN'S NAME (Type):

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 3/17/1959

22c. NAME OF CEMETERY OR CREMATORY: Ringgold Union Cemetery

22d. LOCATION (City, town, or county) (State): Ringgold, Smithsburg, Md. R.D.2

23. FUNERAL DIRECTOR'S SIGNATURE: Walter Y. Gearhart — ADDRESS: Waynesboro, Pa.

24a. REC'D BY REGISTRAR DATE: MAR 19 '59

24b. REGISTRAR'S SIGNATURE: Arthur S. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03664

3651

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: Life
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Washington County Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
d. STREET ADDRESS: 1024 Pope Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ELIZABETH — Middle ANNE — Last SUFFECOOL

4. DATE OF DEATH: Month March — Day 21 — Year 19 59

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Oct. 27, 1952
9. AGE (In years last birthday): 6 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Student
10b. KIND OF BUSINESS OR INDUSTRY: Public School
11. BIRTHPLACE (State or foreign country): Hagerstown, Md.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Kenneth Richard Suffecool Sr.
14. MOTHER'S MAIDEN NAME: Mary Evelyn Barger

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO: None
17. INFORMANT — Address: K.R.Suffecool Sr. 1024 Pope Ave. Hagerstown, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Peritonitis - due to — INTERVAL BETWEEN ONSET AND DEATH: 36 hr

492 X

DUE TO (b) Acute viral pneumonitis + sepsis — 3-4 days

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last — DUE TO (c) Appendicitis -

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Mar 20, 19 59, to Mar 21, 19 59, that I last saw the deceased alive on Mar 21, 19 59, and that death occurred at 6 45 M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Edward W Ditto M.D.
ADDRESS (Street, city or town, state): 217 W. Washington St.
DATE SIGNED

PHYSICIAN'S NAME (Type): Edward W. Ditto III M.D. — Hagerstown, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 3/23/59
22c. NAME OF CEMETERY OR CREMATORY: Rest Haven Cemetery
22d. LOCATION (City, town, or county) (State): Hagerstown Md.

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Rest Haven Funeral Chapel Inc. Hagerstown, Md.
24a. REC'D BY REGISTRAR — DATE: MAR 24 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Keefer

Wm. G. Horst V. Pres.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by [redacted] page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 shall be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3652

CERTIFICATE OF DEATH

03665

Reg. Dist. No. 302

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 23 Yrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 10 So Cannon Ave

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
d. STREET ADDRESS: 10 So Cannaon Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First MARY — Middle JANE — Last THOMAS

4. DATE OF DEATH: Month March — Day 26 — Year 1959

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Feby 7 1878

9. AGE (In years last birthday): 81 yrs
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Hagerstown Wash. Co Md.

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: William Eader

14. MOTHER'S MAIDEN NAME: Susan Angle

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): ----

16. SOCIAL SECURITY NO.: None

17. INFORMANT: John L Thomas — Address: 10 So Cannon Ave Hagerstown Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute broncho-pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 24 hrs
DUE TO (b): Advanced generalized vascular arteriosclerosis
Arteriosclerotic myocardial herat disease
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
DUE TO (c): with myocardial failure

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.): None

20c. TIME OF INJURY: Hour o. m. p. m. — Month, Day, Year: none 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): none

20f. (City or town) — (County) — (State)

21. I certify that I attended the deceased from Oct. 19 38 to Mar. 26 19 59 that I last saw the deceased alive on Mar. 26 19 59, and that death occurred at 2:08 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: S. Robert Wells M.D.
ADDRESS (Street, city or town, state): 115 N. Potomac Street
DATE SIGNED: 3-27-59

PHYSICIAN'S NAME (Type): S. Robert Wells, M.D. — Hagerstown, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 3/28/59

22c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery

22d. LOCATION (City, town, or county) (State): Hagerstown Wash. Co Md

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Andrew K. Coffman Hagerstown Md.

24a. REC'D BY REGISTRAR DATE: MAR 31 '59

24b. REGISTRAR'S SIGNATURE: Arthur L. Hiser

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3678 **CERTIFICATE OF DEATH** 03666

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by [redacted] page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Williamsport
c. LENGTH OF STAY IN 1b: 9 Mo.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Williamsport Sanatarium

2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
d. STREET ADDRESS: 1824 W. Washington st
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First JOHN Middle WILLIAM Last TRULPOWER

4. DATE OF DEATH: Month March Day 17 Year 1959

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: May 3 1875
9. AGE (In years last birthday): 83 yrs
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS: Hours Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer
10b. KIND OF BUSINESS OR INDUSTRY: Retired
11. BIRTHPLACE (State or foreign country): Md. Clear Spring Wash. Co
12. CITIZEN OF WHAT COUNTRY? USa

13. FATHER'S NAME: Peter Trumpower
14. MOTHER'S MAIDEN NAME: Malinda Steffey

15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 213-24-9788
17. INFORMANT: Address: Mrs Nora S. Trumpower 1824W. Wash St Hagerstown Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): CEREBRAL HEMORRHAGE WITH HEMOPLEGIA — INTERVAL BETWEEN ONSET AND DEATH: 18 MONTHS

442 X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): HYPERTENSIVE ARTERIOSCEEROTIC CARDIO-

DUE TO (c): VASCULAR RENAL DISEASE — UNKNOWN

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from OCT 14, 1957, to MARCH 17, 1959, that I last saw the deceased alive on FEB. 12, 1959, and that death occurred at 5:30 P.M., from the causes and on the date stated above.

ADDRESS (Street, city or town, state) DATE SIGNED

ACTUAL SIGNATURE: Archie Robert Cohen M.D.

PHYSICIAN'S NAME (Type): ARCHIE ROBERT COHEN, M.D. CLEAR SPRING, MARYLAND 3/18/59

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 3/21/59
22c. NAME OF CEMETERY OR CREMATORY: St Pauls Cemetery
22d. LOCATION (City, town, or county) (State): near Clear Spring Wash Co Md.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Andrew K. Coffman Hagerstown Md.

24a. REC'D BY REGISTRAR DATE: MAR 23 '59
24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 2,15,17,25,1, 9 11, G241 4-6-59 et

3653

Item 3, Form G241, 4/58 Rev

03667

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Wash. — MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE XXXXXXXXXXMd. b. COUNTY Washington

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown

c. LENGTH OF STAY IN 1b

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Wash. Co. Hosp.

d. STREET ADDRESS: 146 N. Jonathan

e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First Lester — Middle — Last Tutt

4. DATE OF DEATH: Month 3 — Day 21 — Year 1959

5. SEX: M

6. COLOR OR RACE: Col

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: ? Approx.

9. AGE (In years last birthday): 82 yrs

IF UNDER 1 YEAR: Months — Days

IF UNDER 24 HRS.: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): ?

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): ?

12. CITIZEN OF WHAT COUNTRY: ?

13. FATHER'S NAME: ?

14. MOTHER'S MAIDEN NAME: ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): ? (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Hemorrhage
DUE TO
(b): Hypertensive Cardio Vascular Disease
DUE TO
(c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: 2 weeks

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Mar 7, 1959, to Mar 21, 1959, that I last saw the deceased alive on May 21, 1957, and that death occurred at 1:35 M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Robert P. Conrad M.D.

ADDRESS (Street, city or town, state): 137 W. Washington

DATE SIGNED: 3-24-59

PHYSICIAN'S NAME (Type): Robert P. Conrad

Hagerstown Md.

22a. BURIAL, CREMATION, REMOVAL (Specify)

22b. DATE THEREOF: 3-24-59

22c. NAME OF CEMETERY OR CREMATORY: U. of Md. Med. School

22d. LOCATION (City, town, or county) (State): Baltimore Md.

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS

24a. REC'D BY REGISTRAR DATE: MAR 26 '59

24b. REGISTRAR'S SIGNATURE: Arthur L. Thomas

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3654

CERTIFICATE OF DEATH

03668

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 7 hrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Washington County Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Hagerstown R#2
d. STREET ADDRESS: Rural
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: EMMA Middle: CATHERINE Last: WATKINS

4. DATE OF DEATH: Month: March Day: 22 Year: 1959

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Feb.20,1879

9. AGE (In years last birthday): 80 yrs. IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Practical Nurse

10b. KIND OF BUSINESS OR INDUSTRY: Medical

11. BIRTHPLACE (State or foreign country): Fulton County, Penna.

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Ephraim B.Lake

14. MOTHER'S MAIDEN NAME: Mary Jane Harr

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 072-03-0281

17. INFORMANT: Robt.E.Myers Address: R#2 Hagerstown, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): MASSIVE CEREBRAL HEMORRHAGE — INTERVAL BETWEEN ONSET AND DEATH: 12 HRS

+43X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

DUE TO (b): HYPERTENSIVE ARTERIOSCLEROTIC HEART

DUE TO (c): DISEASE — UNKNOWN

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): NONE

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that I attended the deceased from MARCH 21, 1959 to MARCH 22, 1959 that I last saw the deceased alive on MARCH 22, 1959 and that death occurred at 1:45 AM from the causes and on the date stated above.

ADDRESS (Street, city or town, state) DATE SIGNED

ACTUAL SIGNATURE: Archie Robert Cohen M.D.

PHYSICIAN'S NAME (Type): ARCHIE ROBERT COHEN, M.D. CLEAR SPRING, MD. 3/23/59

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 3/24/59

22c NAME OF CEMETERY OR CREMATORY: Rest Haven Cemetery

22d. LOCATION (City, town, or county) (State): Hagerstown Md.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Rest Haven Funeral Chapel Inc. Hagerstown, Md.

24a. REC'D BY REGISTRAR DATE: MAR 26 '59

24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

Wm. G. Host V-Pres.

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed filled in by funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3655

CERTIFICATE OF DEATH

Reg. Dist. No. 0366

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 38 years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Washington County Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)
a. STATE: Maryland — b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
d. STREET ADDRESS: 816 Lanvale St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Maude — Middle Stella — Last Williamson

4. DATE OF DEATH: Month March — Day 9 — Year 1959

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Mar. 31, 1869
9. AGE (In years last birthday): 89 yrs
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Bentonville Va.
12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: Joseph Matthews
14. MOTHER'S MAIDEN NAME: Rachael Waters

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): ---
16. SOCIAL SECURITY NO.: ---
17. INFORMANT: Owen Williamson — Address: Hagerstown Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Arteriosclerosis with Mental Deterioration — INTERVAL BETWEEN ONSET AND DEATH: 4 years
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Coronary Arteriosclerotic Heart Disease
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year, Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 2-7, 1959, to 3-9, 1959 that I last saw the deceased alive on 3-7, 1959, and that death occurred at 3:11 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: Dalton M. Welty M.D.
ADDRESS (Street, city or town, state): 998 Potomac Ave. Hagerstown Md.
DATE SIGNED
PHYSICIAN'S NAME (Type): Dalton M. Welty

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 3-11-59
22c. NAME OF CEMETERY OR CREMATORY: Baptist Cemetery
22d LOCATION (City, town, or county) (State): Bentonville Va.

23. FUNERAL DIRECTOR'S SIGNATURE: Scott F. Minnich & Son
ADDRESS: Hagerstown Md.
24a. REC'D BY REGISTRAR DATE: MAR 11 '59
24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03670

3679

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown R # 2
c. LENGTH OF STAY IN 1b: 40 Yrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Hopewell Road

2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission)
a. STATE: Maryland — COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Hagerstown R # 2
d. STREET ADDRESS: Hopewell Road
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First JOHN Middle JACOB Last WINTERMOYER

4. DATE OF DEATH: Month March Day 10 Year 1959

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Dec. 5 1879
9. AGE (In years last birthday): 79 yrs
IF UNDER 1 YEAR: Months ___ Days ___ IF UNDER 24 HRS: Hours ___ Min ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer
10b. KIND OF BUSINESS OR INDUSTRY: Retired
11. BIRTHPLACE (State or foreign country): Johnsontown Morgan Co W. Va
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Charles F. Wintermoyer
14. MOTHER'S MAIDEN NAME: Dorothy E. Turner

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No (If yes, give war or dates of service): ------
16. SOCIAL SECURITY NO.: None
17. INFORMANT Address: C. Fred Wintermoyer Hagerstown Md. R # 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c)]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ____ INTERVAL BETWEEN ONSET AND DEATH

420.0 DUE TO

Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.

(b) Arteriosclerotic Heart Disease — 3 yrs

DUE TO (c) ____

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 2-1-59, 19___, to 3-10-59, 19___, that I last saw the deceased alive on 3-7-59, 19___, and that death occurred at 7 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Andrew K. Coffman M.D. ADDRESS (Street, city or town, state): Hagerstown Md. DATE SIGNED: 3/10/59

PHYSICIAN'S NAME (Type): ANDREW K. COFFMAN

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 3/13/59
22c. NAME OF CEMETERY OR CREMATORY: Hedgesville Cemetery
22d. LOCATION (City town, or county) (State): Hedgesville Morgan Co W.Va

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Andrew K. Coffman Hagerstown Md.
24a. REC'D BY REGISTRAR DATE: MAR 13 '59
24b. REGISTRAR'S SIGNATURE: Arthur L. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

3680

03671 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Hancock Md
c. LENGTH OF STAY IN 1b: 42 Yrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Home

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Rural Hancock Maryla nd.
d. STREET ADDRESS: Rural 2 Hancock Md.
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First Cora — Middle May — Last Younker

4. DATE OF DEATH: Month 3 — Day 19 — Year 1959

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 4.16.1893

9. AGE (In years last birthday): 65 yrs.
IF UNDER 1 YEAR: Months 11 — Days 3
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Housewife

11. BIRTHPLACE (State or foreign country): Franklin County Penna.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Powel Bivens

14. MOTHER'S MAIDEN NAME: Jane Paylor

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: None

17. INFORMANT — Address: Simon C Younker Rural 2 Hancock Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Heart attack — INTERVAL BETWEEN ONSET AND DEATH: 20 min.
434.4
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Acute Cholecystitis , Urinary retention

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from on Mar. 19, 1959 to _____, 19____, that I last saw the deceased alive on March 19, 1959, and that death occurred at 1:30 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Frank B Thomas III M D M.D.
ADDRESS (Street, city or town, state): 121 High Street, Hancock, Md.
DATE SIGNED:

PHYSICIAN'S NAME (Type): Frank B. Thomas III MD

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 3.23.59
22c. NAME OF CEMETERY OR CREMATORY: Stone Bridge Brethern
22d. LOCATION (City, town, or county) (State): Near Hancock Washington Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Howard F Hoover
ADDRESS: Hancock md

24a. REC'D BY REGISTRAR DATE: MAR 26 '59
24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3656 CERTIFICATE OF DEATH

03672

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 19 yrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Washington County Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 03 Hagerstown
d. STREET ADDRESS: 227 Alexander St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First LAVINA Middle MILDRED Last ZIMMERMAN

4. DATE OF DEATH: Month March Day 11 Year 1959

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: October 16,1924
9. AGE (In years last birthday): 34 yrs.
IF UNDER 1 YEAR: Months ___ Days ___
IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Waitress
10b. KIND OF BUSINESS OR INDUSTRY: Restaurant
11. BIRTHPLACE (State or foreign country): Baltimore,Md.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Raymond B.Watt
14. MOTHER'S MAIDEN NAME: Gertrude Crome

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 219-18-2498
17. INFORMANT: Vernon C.Zimmerma n Address: 227 Alexander St. Hagerstown,Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Uremia — INTERVAL BETWEEN ONSET AND DEATH: 10 days
442 ×
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Arteriolarnephrosclerosis — 2 yrs. 1mo.
DUE TO
(c) Hypertensive cardiovascular disease — 2 years 1mo. (certain)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Hemiparesis, right
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour ___ a. m. p. m. Month ___ Day ___ Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Dec. 9, 1958, to March 11, 1959, that I last saw the deceased alive on March 11, 1959, and that death occurred at 5:40 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: William T. Layman M.D. — ADDRESS (Street, city or town, state): 100 Professional Arts Bldg. Hagerstown Maryland — DATE SIGNED: 3/13/59

PHYSICIAN'S NAME (Type): William T. Layman, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 3-16-59
22c. NAME OF CEMETERY OR CREMATORY: Rest Haven Cemetery
22d. LOCATION (City, town, or county) (State): Hagerstown Md.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Rest Haven Funeral Chapel Inc. Hagerstown,Md.
24a. REC'D BY REGISTRAR DATE: MAR 16 '59
24b. REGISTRAR'S SIGNATURE: Arthur L. Kline

Wm. G. Host M.D.